Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Frank J. Letkiewicz 12:45am Medical October 2010 Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery Social Security Number 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 1 X M 2 D F Hours (Month, Day, Dril Director 178-28-2443 Pennsulvania "natural", or items 23a or 28a-f show adical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits Maryland Montgomeru 1 🗌 Yes 2 🗓 No Silver Spring 10f. Zip Code 10g. Citizen of What Country? 9703 Armistead Road 20903 U.S.A 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 1942 -11. Marital Status Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, δ 1 Never Married 2 X Married Black White etc. Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 X No Specify: 3 Widowed 4 Divorced Completed 1946 Caucasian the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Civil Engineer D.C. Dept. of Highway Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be Frank Joseph Letkiewicz Gertrude Zielezinsai 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Blanche A. Letkiewicz/Spouse 9703 Armistead Rd., Silver Spring, Maryland 20903 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Gate of Heaven Cem. 11/05/2010 Silver Spring, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Signature of Funeral Service Licensee 11800 New Hampshire Ave., Silver Spring, MD20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Hepatorenal Syndrome Onset and Death disease or condition resulting in death) Due to (or as a consequence of) Examine Metastatic Liver Cancer Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated avents Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 - Fetal death in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Vear 1 ∐ Yes 2 I 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? History of Laryngeal Cancer Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗓 Unknown History of Bladder Cancer Were autopsy findings available prior to completion of cause of 24a. Was an performed' death? 2 **X** No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 DOther (Specify) HOSpice မ 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA After thi 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 \(\text{Yes} \) 2 \(\text{No} \) 1 X Natural 5 Pending injury thin 24 hours after death.

the Funeral Director: Af
ampleted filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. o the within 2 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0060634 October 29. 2010

State Registrar

DHMH 17 Rev 7/2009

6001 Muncaster Mill Road, Rockville, Maryland 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.,

Bindu Joseph,

31. Date filed (Month, Day, Year) **MOV**: 0.3 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Louder Reese Larrimore Louder Reese Larrimore	_	L State Registrar		Certificate of	Death		g. No.	A 1.2550
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Specific contribution Spec	<u></u>	24918 Taylor Road						
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Patty Porter daughter 328 Longfellow Drive; Chestertown, MD 21620 206. Location - City of Town, State 206. Place of Disposition (Name of Location - City of Town, State 1.1 Many 2 Certification 3 Removal from State 2.1 Many 2.2 2.2 2.3	٩							tata Zin Cada)
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21. Signature of priefred Service Licensee Fleegle and Helfenbein Funeral Home, PA POB 160 Greensboro, Maryland 21639 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of ging, such as cardiac or respiratory arrest, interval Between Chaese (head for the state) and the cause of the death. Do not enter the mode of ging, such as cardiac or respiratory arrest. Approximate Interval Between Chaese (head for the state) and the cause of the ca		1 XBurial 2 ☐ Cremation 3 ☐ Rer	moval from State		1		Felton	Delaware
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29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year)	٤.	1 res 2LANO	1 □ Inpatient 2 □ EH/t	Jutpatient 3 DOA	4 Li Nursing I			
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29b. Signature and fittle of certifier 29c. License number 29d. Date signed (month, sty) to the sign	ertifica	(Check only 2/ Medical Examin	On the basis of examination	ige, death occurred at the and/or investigation, in my	time, date and place opinion, death occ	e, and due to the urred at the time,	cause(s) and mai date and place, a	nner as stated. nd due to the cause(s)
29b. Signature and fittle of certifier 29c. License number 29d. Date signed (month, sty) to the sign	cal Certifica		and manner stated.					
20. Name and address of person who completed cause of death (Itam 23a) (Type, Print)	edical			29C, LICE	use minimer		Louis Signed	,,
20. Name and address of person who completed cause of death (Item 23a) (Type, Print)	edical		/	00	1000	1/	10/0	2/17
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36503 State Registra AMEND#19aperFH, 11/3/10EMW, MoCertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 27-2010 1233 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner County of Death ountry narunde Harwood 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** United Kingdom 1 □ M 2 X F (Month, Day, Yea 224-76-6859 91 Min. Director Usual Residence of Decedent or 28a-f show artment of Health and Mental Hygiene. ortants I fitem 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Completed by Funeral Director 10d. Inside City Limits Fairfax Alexandria VA 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 22310 Westridge SA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?,
1 ☐ Yes 2 🗶 No Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give 3 X Widowed 4 □ Divorced Specify: Year or Dates aucasian 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home Own Ma 12 Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Hayden Bevan Jones Dora 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20719permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra McKay William H. --son Island Dolomons Iracus! 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location City or Town, State 1 Burial 2 Cremation 3 Removal from State 2 4 Donation 5 Other (Specify) Alexandria 2010 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 5308 Backlick Rd. ccosiz Demaine Sprinofield Perrera tuneral tome 23a. Part 1. Enter the disease, old omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death Physician/ QUIS disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or darrying Cause (Disease or linjury that initiated events resulting in death) Last Certificate: To Be Completed by Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed bunial-transi Due to (or as a consequence of): attending physician for use as the buria Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery ☐ Live Birth 2 ☐ Fetal 300...
☐ Pregnant at time of death
☐ Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month signed by the at the detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? STROKE 2 ☐ No 3 ☐ Probably 4 ☐ Unknown DEMENTIA Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s performed No death? certificate 2 🗌 No 1 🗌 Yes **Division of Vital** the Hospital or Attending Physician: 25. Was case referred to medical director, 26. Place of Death (Check only one) examiner? Other: 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending Investigation Could not be 2 No Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 20 838

Registrar

State

Name and address of person who completed cause of death (I)

31. Date filed (Month, Day, Year)

em 23a) (Type, Print)

Mis

32. Registrar's Signature

ER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day}2010 Physician/ October 28, 3:45 p McEnaney, Jr. Aloysious Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 DC Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 84 Yrs. Days (Month, Day, Year) 577-40-4239 1 M 2 | F Oct. Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD P.G. Adelphi 1 🗌 Yes 2 🍱 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20783 USA Funeral 2712 Hughes Road death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 2 No WII 1 Never Married 2 Married Completed by Yes, Give Maryland 21215-0036 72 hours after Specify: White 1 ☐ Yes 2 😾 No Specify: "natural", 3[™] Widowed 4 □ Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Dernit. Page 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than any injury or other traumatic man. U.S. Government Elementary/Seconday (0-12) College (1-4 or 5+) Lithographer Printing Office Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Marie Ryan James A. McEnaney, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 153 East 57th Street, Apt. 5J, New York, NY 10022 William McEnaney/Brother altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Arlington National
Cemetery 1 H Burial 2 Cremation 3 Removal from State Arlington, VA 2010 4 Donation 5 Other (Specify) 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 000 University Blvd. W., Silver Spring, MD 20901 21. Signatury of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one-cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Typician/ Cardiorespiratory Arrest disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Cerebrovascular Accident Sequentially list conditions, if an leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events Atherosclerotic Cardiovascular Disease burial-transi and Due to (or as a consequence of) resulting in death) Last physician the burial Physician/Medical Diabetes Mellitus, Type II The law requires that the death certificate be Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ned by the atten detached for u in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown Division of Vital Records, P.O. signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cirrhosis, Osteomyolitis of Lumbar Spine, Epidural Abcess 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 No 2x N Yes To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 2XX No Other: 1 Sympatient 2 ER/Outpatient 3 DOA မ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

State Registrar 29b. Signature ang tjûe

Oney Zuniga, MD 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4701 Randolph Road, #216, Rockville, MD 20852

. Registrar's Signature

29d. Date signed (Month, Day, Year) November 1, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	arylan			nt of H		and N		giene Reg. No.	010	36505
	Physicia Medic		1. Decedent's Name (First, Middle, Elena Flores De								2. Date of Dea Month October		201 ^{Year}	3. Time of Death 12:16 A M
	Examir		4a. Facility Name (if not institution, g			- "			Location of	f Death			ounty of Death	
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	Funeral Director		None Usual Residence of Decedent	1 ☐ M 2 🕱 F	e (In yrs. Ia 96	yrs.	Months		Hours	Min.	8. Date of Birtl (Month, Day Nov • 30	Year) 191	9. Birth	place (State or Foreign try) LCO
	ind show at	P	10a. State 10b. County		10c. City	, Town or Lo	cation						1	0d. Inside City Limits
	Aaryla 8a-f s tiffied	Director	Maryland Montgo	nery	Ger	mantov	m							1 ☐ Yes 2 🛣 No
	with the N 23a or 2 ust be no	Funeral Di	10e. Street and Number 11900 Isen Mano	r Drive				ip Code 1876				-	n of What Cour Mexico	ntry?
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show array injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ※ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.		'	f Yes, spe	edent of His ecify Cubar 2 No	n, Mexican,	Puerto	ecify Yes or No- Rican, etc.)		Race - Americ Black, White, ecify:	
21215-0036	thin 72 housne. than "nati he Medica	Completed	15. Decedent (Specify only highest Elementary/Seconday (0-12)		5+)	Ìife. D	kind of w	ork done d e retired)	ition uring most	of work	ing		of Business In	dustry
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lan	l be fil fental rked tic ev	욘	Maximo Flores								Reffugio			
Maryland	12 should alth and M 27 is ma r traumai		19a. Informant's Name/Relationship Guadalupe Guzman		ghter	19b. Mailir 1190	ng Addres 0 Is	s (Street a	nd Number	or Run	al Route Number e, Germa	City or Tov	wn, State, Zip 0 n , MD 2	0876
Baltimore,	age 1 and ent of Hea nt: If item y or othe		20a. Method of Disposition 1		20b. Pi	lace of Dispo emetery, cren tropol Cremat	sition (Na natory or 1tar	me of other place	9 0	c t ol 201	per 29,		tion - City or To	
Balti	permit. Pag Departmen Important: any injury once.		21. Signature of Euneral Service Light			22	. Name a	nd Addres	s of Facility	De	Vol Fun	eral	Home,	Virginia , MD 20877
	Physician/ Medical Examiner physician and and and and and and and and and a	dical Examiner	Sequentially list conditions, if any, leading to immediate cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events resulting in death) Last	a. Cardio Due to (or as b. Due to (or as c. Due to (or as	-Vasc a consequ a consequ	ence of): ence of):)isea	ise						Interval Between Onset and Death
. Box 6876	Attending Physician: The law requires that the death certificate be executed ar death. **redeath.** **ector.** After this certificate has been signed by the attending physician and extor. After this certificate has been signed by the funeral director, page 2 should be detached for use as the burial-transit op the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal	Ideath 3 🗌	Ectopic Other (s	pregnancy pecify)	/			230	d. Date of delive	ery Day Y ear
s, P.O.	requires that the been signed by should be detacted	2	Part II. Other significant condition Constipat:	-	ut not resu	ulting in the u	nderlying	cause give	en in Part I.					ne cause of death?
Division of Vital Records,	The law requate has beer page 2 shou	Completed									24a. Was a autop perfor	med?	24b. Were autop prior to co death? 1 \(\sum \) Yes	osy findings available mpletion of cause of
E	ician: The certificate ector, pag	Be C	25. Was case referred to medical examiner?			-			ce of Death	n (Checi				
Ξ	Physic this or al dire	은	1 🔀 Yes 2 🗆 No			ER/Outpatier			4 ⊔ Nur	sing Ho	me 5 X Resid	ence 6 🗌	Other (Specify)
o uoi	tending Feath. or: After the funer	Certificate:	27. Manner of Death 1 🔀 Natural 5 Pending 2 Accident Investiga 3 Suicide 6 Could no			28b. Time of injury	М	28c. Injury work? 1 🗀 `			28d. Describe ho	w injury oc	ccurred	
Divis	ital or Att irs after d al Direct led in by		4 Homicide determin				et, facto	y, office			28f. Location (Si City or Town		umber or Rural	Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director,	Medical	(Check 2 Medical Exa	Physician: To the best of aminer: On the basis of elurse Practioner: To the	xamination	and/or invest	tigation, ir	my opinior	n, death occ	curred at	the time, date ar	d place, an	d due to the car	use(s) and manner stated.
	Verith Verith		29b. Signature and title of certifier	1				c. License					igned (Month, I	
			100					59013	3			Octob	er 29,	2010
			30. Name and address of person with Konstantin A. K	nludenev, M	.D.,	15825	Shad		ove R	oad,	#140,	Rocky	ille, N	∕D 20850
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registra	ır's Signatı	re dec	N. S							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day CLARA ELIZABETH MOFFITT 2010 5:50 Nov 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Cecil Sunny Acres North East If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1□ M 2√X Months 423-32-2698 90 3/20/1920 Warwick, MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 No Cecil MD Warwick 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 35 Wilson Street 21912 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married 1 ☐Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Tractor Equipment Bookkeeper 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Laura Benetta Husfelt Charles William Pierce 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anita Smith/Daughter 912 Colonial Court, Coatesville, PA 19320 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State Warwick Cemetery 11/6/2010 Warwick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DANIELS & HUTCHISON FUNERAL HOME LLC 212 N. Broad St., Middletown, DF Approprietations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approprietations and the death. 19709 23a. Part 1. Enter the disease, or shock, or heart failure. List of Approximate Interval Between Onset and Death Immediate Cause (Final I neumon or disease or condition resulting in death) Due to (or as a consequence of) COPD 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 9 Unknow 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown

Physician /Medical Examiner

> and burial-trar

the attending physician

cate has been signed by page 2 should be detach

certificate

this funeral c

after death filled in by the

24 hours a

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Hospital or Attending Physician: The law requires that the death certificate be executed

P.O. Box 68760.

Division of Vital Records,

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Examiner

Physician/Medical

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Certification: To

Medical

2 Accident

4 Homicide

(Check only one)

3 Suicide

29a. Certifier

Funeral

Director

should be filed within 72 hours after death with the Maryland

altimore, Maryland 21215-0036

?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Moulcal Exp. directrust be rediffed at

nd Mental Hygiene. marked other than

Health and Mental em 27 is marked o

other t

permit. Pages 1 and Department of Heal Important: If item 2 any injury or other once.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 No 24a. Was an autopsy performe

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 □ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 1 Natural 5 Pending

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred

1 ☐ Yes 2 5

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

12 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier carlls.

investigation

determined

6 ☐ Could not be

29c. License number DO4823

29d. Date signed (Month, Day, Year)

man et E/HOZ MI 2192)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HSU CHIH MD

31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	•	State Amend Item	m 29d per dr	aryland/[Peradoe Certificat	nt of Health te of Death	h and Me h	ntal Hyg F	giene 1	0 3650	1
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Physici Medi		Paul Joseph			1			ctober		10 1:40 P	М
Exami	ner	4a. Facility Name (if not institution				, Town, or Locatio	on of Death		4c. County of	of Death ington	
Funeral		14160 Orchard 5. Social Security Number	6. Sex 7. Age	e (In yrs. last birtl	nday) If Unde			. Date of Birth	1	9. Birthplace (State or Forei	ign
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036 rs afte	ed b	3 ☐ Widowed 4 ☐ Divorced	If Voc Give	140	1 🗆 Yes	2 X No Spec	cify:		Specify:	White	
5-C 2 hou "natu	Completed		ent's Education est grade completed)	16a.	Decedent's Usi (Give kind of wo	ork done during m	nost of working		16b. Kind of Bu	siness Industry	- 1
ithin 7	S	Elementary/Seconday (0-12)	College (1-4 or 5	i+)	life. DO NOT us Mechan	,			Automot	ive Repair	
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam	Be	17. Father's Name (First, Middle,	Last)		Heenan		other's Name (F	First, Middle, I	Maiden Surname,		
ylar Id be 1 Menta arked atic er	မြ	Roy C. Moats				Br	idget A	. Well	er		
Mar shou and rism raum		19a. Informant's Name/Relations	. (3)	1		•			; City or Town, St		
and 2 Health tem 2		Patsy I. Moat 20a. Method of Disposition	s/Wife	-	Disposition (Na		dge Roa		ock, MD 2	Z1/50 City or Town, State	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic area.		1 🔀 Burial 2 □ Cremation 4 □ Donation 5 □ Other (y, crematory`or Bridge	_{other place)} Cemetery			Hancock	•	
Baltimore, bermit. Page 1 and Department of Hea Important: If item any injury or other once.	1 3	21. Sematury of Funeral Service		Tocone					ain Stre		
m 82 E 8 8	V 0	Kelw) Delon	M00260						21750-0368	- 1
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Physician/ Medical	7 0	disease or condition resulting in death)	a. HAO 6	d Vede	Concor	of pan	alu o	191-1		2-346	_
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dires in sign								1 🗆 ነ	res 2 No	3 ☐ Probably 4 ☐ Unkno	wn
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Vital Reco sician: The law certificate has t irector, page 2 s	Sol							perfor 1 Yes		leath?	
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Division of Vital Re lal or Attending Physician: The Is after death. al Director: After this certificate It ed in by the funeral director, page	e: To	27. Manner f Death	28a. Date of inju		ime of	28c. Injury at			lence 6 🗆 Othe ow injury occurre		
on ending sath. or: Afte	Certificate:		igation	, rear)	njury M	work? 1 ☐ Yes 2	2 □ No				
VISIOI r Attencter death	I≑	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deterr			rm, street, facto	ry, office	28	f. Location (S City or Town		r or Rural Route Number,	
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Div spital or lours aft leral Dir filled in		29a. Certifier 1 Cortifuin	a Physician: To the best of	my knowledge	death occured a	it the time, date a			, ,		
Div ne Hospital or n 24 hours aft ne Funeral Di		(Check 2 Medical	g Physician: To the best of Examiner: On the basis of e g Nurse Practioner: To the	xamination and/o	r investigation, ir	my opinion, death	h occurred at the	e time, date ar and due to the	nd place, and due e cause(s) and ma	to the cause(s) and manner st	tated.
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To the Hospital or within 24 hours aft To the Funeral Discompleted filled in St.	Medical	(Check only one) 3 ☐ Certifyin 29b. Signature and title of certifie 30. Name at placetees of person Jeffrey Hurwi 31. Date filed (Month, Day, Year)	Examiner: On the basis of eg Nurse Practioner: To the practioner: To the praction of the completed cause of data, M.D. 1111	xamination and/obest of my knowledge of my kno	r investigation, ir edge, death occ	n my opinion, death urred at the time, of the License number	h occurred at the date and place, a er	and due to the	e cause(s) and mai	to the cause(s) and manner st nner as stated. (Month, Day, Year)	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1545 PM NORRIS CTUBER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORI n/a BAYVIEW MEDICAL CENTER If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral 1 🕅 M 2 🗆 F Months Days Hours Min. 11 1 1 3 7 1 9 2 4 Director 219-18-7091 85 Maryland Usual Residence of Decedent ıral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Tes 2 No MD Calvert Owings 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 20736 USA 9110 Southern Maryland Boulevard within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 X Yes 2 No Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. 1941-44 1 ☐ Yes 2 🗓 No Specify. Specify: "naturaf" Completed 3 X Widowed 4 □ Divorced white the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 farmer agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sr. Helen Ellen Mitchell Mitchell Anderson Norris, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melvin A. Norris III 8825 So. MD Blvd., Owings, MD 20736 son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 Department of Important: If it any injury or o Page 1 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) So. Memorial Gardens 11-04-2010 Dunkirk, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ₹nysician/ VENTRICUCAL MINUTES FIBRILLATION disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner MYOCARDIAL MINUTES FNFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine YEARS sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events CORONAR HRONIC Due to (or as a consequence of): resulting in death) Last physician the burial Physician/Medical attending p IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown in the past 12 months? Month Pregnant at time of death 2 No 9 Unknown P.0 been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 9 % JOTAL BODY SURFACE AREA SECOND DEGREE BURNS Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? MYOCARWAC FAPARCTION 24a. Was an autopsy page PACEMAICER PLACED ATROX. 5 YEARS AGO PREVIOUS 1 ☐ Yes 2 ☐ No after death.

Director: After this certific
I in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 No **Division of Vital** 26. Place of Death (Check only one) Hospital: မ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, 1 Natural 2 Accident injury 5 Pending work? 1 ☐ Yes 2 No 2912010935 Investigation 3 Suicide 4 Homicide 28f. Location (Stre t and Number or Rural Routh Tumber, OW NS 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined City or Town, State) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Name Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) RES-000 OCTOBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 AVE BALTIMORE MD

State Registrar 31. Date filed (Month, Day,

Registrar Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 1 - For State Registrar Certificate of Death Rea. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Nov. 2, Suzanne Barbara NEWMARK 2010 4:45 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville 10019 Vanderbilt Circle #13 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Sept. 12, 1942 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. 1 □ M 2 K Hours Months Days New York 68 112-34-7650 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examination must be recitived at Rockville Maryland Montgomery 1 ☐ Yes 2 ☑ No Directo death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20850 United States 10019 Vanderbilt Circle #13 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 □ Yes 2 No Specify: \$ Specify: white 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ and Mental Hygiene. Elementary/Secondary (0-12) Realty Graphic Artist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Kassof Bernard Silverman ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5816 West Woodbridge Place, Peoria, IL 61615 19a. Informant's Name/Relationship (Type. Print) Item 27 is other tra Beth Uretzky, Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) of Department of Important: If It any injury or conce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Patchoque Hebrew Cemetery 11/05/10 Holtsville, NY 4 Donation 5 Dother (Specify) 401008 Törkminsky Hebriew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Small Cell Lung Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 No cate has been signed by the a page 2 should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1)√□ Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate ! 1 ☐Yes 2¥ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) After this Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No spital or Attendi nours after death. neral Director: ≠ 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier November 3, 2010 D 0062234

Registrar DHMH 17 Rev 1/200

State

31. Date filed (Month, Day, Year) NOV U 4 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U | U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 2, Barbara Mary Ost 2018 12:30 рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Lorien Nursing & Rehabilitation Ctr Taneytown Carroll If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months Hours 1 M 2 K F NOV 6 P 1917 213-03-5879 92 Mary land Yrs Director Usual Residence of Decedent 10a. State 10b. County an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Sarasota Florida Sarasota 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 730 South Osprey Street 34236 USA should be filed within 72 hours after death vand Mental Hygiene. Is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. <u>۾</u> 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Teamsters Union 12 Secretary Be permit. Page 1 and 2 should be filed. Department of Health and Mental P. Important: If item 27 is many injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Benjamin Bauer Marion Clagett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Neuberger, nephew 504 Catskill Ct, Millersville, MD 21108 20a. Method of Disposition 20b. Place of Disposition (Name of Script Incrematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 11/03/2010 Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Myers-Durboraw Funeral Home 136 E Baltimore St, Taneytown, MD 21787 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caust Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical e to (as a consequence of Examiner Sequentially list ponditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year s been signed by the should be detached 9 Unknown Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy death? performed' certificate 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 1 No Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work nours after death neral Director: A filled in by the fo 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral C completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Sign cause of death (Item 23a) (Type_Print) Ohn 31. Date filed (Month, Day, Year, NOV 03 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year Catherine Ann Osborn 1:00 PM /Medical November 08. 2010 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Candle Light Cove Assisted Living Easton Talbot If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Hours Min. July 22 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Months Days 1 ☐ M 2 🗓 F Nebraska Director 506-30-9760 78 Usual Residence of Decedent death with the Maryland 10a. State 10b. County or 28a-f show 10c. City. Town or Location 10d. Inside City Limits id other than "natural", or items 23a or 28a-f showevent, the Medical Examination must be notified at Director 1 ☐Yes 2XTNo Maryland Queen Anne Stevensville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 465 Creeks End Lane 21666 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 XNo \$ Specify Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker h and Mental Hygie own home permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy Important: If item 27 is marked other any injury or other the contract of the contrac 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Patrick James Heaton Catherine Gutting ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Oakley E. Osborn/ husband 465 Creeks End Lane; Stevensville, Maryland 21666 20b. Place of Disposition (Name of cemetery, crematory or either place 20a. Method of Disposition
1 ☐ Burial 2 ② Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation Nov 13 2010 Chester, Maryland 22. Name and Address of Facility PO Box 160; Greensboro, MD 21639 21. Signature of Funeral Service Licenses Fleegle and Helfenbein Funeral Home, PA 23a. Part 1. Enter the disease, or complications that odused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Organie Bran disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed Due to (or as a consequence of): burial Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Month Year 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) signed by the a d be detached f P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ №6 3 ☐ Probably 4 ☐ Unknown the Hospital or Attending Physician: The law 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 24a, Was an autopsy 1 ☐ Yes 1 ☐Yes 2 ☐No 2 40 director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28d. Describe how injury occurred 1 Natural 5 Pending death. 2 Accident investigation 1 ☐Yes 2 No 24 hours after deatl Funeral Director: filled in by the 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifie completely (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Commerce Du # 106 EXSTEN, my

DHMH 17 Rev 1/2001

State Registrar 8579

82. Registrar's Signature

Delean.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

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			For	State of Ma	-	-		nd Mental H	ygiene	110	00010
			State Registrar		(Certificate	of Death		Reg. No.	JIU.	30013
	Discontata	/	Decedent's Name (First, Middle, I	Last)				2. Date of I			3. Time of Death
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-	/		9809 Bethesda C	Church Road.	#201		Damasc	us		Montgo	этоли
	Funeral			S. Sex 7. Age	(In yrs. last birtho		Year If Under 24	Hrs. 8. Date of E	Birth	0. Dietholos	Ctata - F
м	Director		216-38-5602	1 X M 2 □ F	69 Y	s. Months D	ays Hours	Min. July	23.1941	Country)	Maryland
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	death item item		11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	13. Was Decedent	of Hispanic Origin	n? (Specify Yes or No Puerto Rican, etc.)	D- 14. Ra	ace - American I	ndian,
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4	thin in the same.	νoί	Elementary/Seconday (0-12)	College (1-4 or 5-) //	e. DO NOT use rei	ired) Worker		Tauva	1 Chan	Chara
2	e filed within 72 hours after death with the Maryland ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ادہ	12	.1		cry				6 Chevy	chase
E S	be filed ental Hy ked oth ic event	일	17. Father's Name (First, Middle, Las				18. Mother's	s Name (First, Middle	·		
ž	ould be fiil nd Mental marked matic ev			James Palme	て			Kebe	cca Jack	eson	
<u>Nai</u>	should In and Me		19a. Informant's Name/Relationship			-		or Rural Route Numb			•
4	and 2: Health tem 27		Rose Ann Palmer	<u> – Spouse </u>	1			h Rd., #2			
9	le 1 and t of Heal If item 5 or other		20a. Method of Disposition 1 □ Burial 2 X Cremation 3	☐ Bernoval from State	20b. Place of D cemetery,	isposition (Name of crematory or other	of r place)	Date	20c. Location	- City or Town,	State
<u>Ξ</u> .	Page ment o tant; If lury or		4 Donation 5 Other (Spe		Ft. Liv	coln Cre	matory 1	1/03/2010	Brentwo	od. Mar	ryland
Baltimore, Maryland 21215-0036	pemit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic once.		21. Signature of Funeral Service Lice	ensee	- 0			Simple Tr			
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ر	Medical		resulting in death)		consequence of)					7	MONUNS
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Box 6876	death certificate be executed ne attending physician and ed for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o					23d. D	ate of delivery	
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MOV 03 2010

Paul Thambi, M.D., 9707 Medical Center Drive, Suite 300, Rockville, MD 20850 31. Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death March month 4a. Facility Name If not institution, give street and number b. City. Town, or Location of Death 4c. County of Death The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Yea 7/8/2010 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 220-87-9867 1 M 2 X F 3 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Anne Arundel Edgewater 1 Yes XXNo 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 21037 1620 Bishop Rd. USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 🛣 No White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 0 N/AN/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Andrew F. Pipari Julie M. Pilgrim 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrew Pipari Father 1620 Bishop Rd. Edgewater, MD 21037 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Atlantic Crematory 11/10/2010 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 70 22. Name and Address of Facility Hardesty Funeral Home, P.A. 78 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ü disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of):

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical

Examiner

Funeral

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To the Funeral D

completely filled

To the Hospital or Attending Physiclan: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

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by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		opic pregnancy er (specify)		23d. Date of delivery Month Day Year
	Necrotzi	ontributing to death but not resulting in the under	lying cause given in Part I.	1 🗆 Ye	7
Be Completed	Patch Du 25. Was case referred to medical	chs Artemosus	26 Place of Dea	24a. Was an autopsy perform 1 Yes 2	/ prior to completion of cause of death? 2 □ No 1 □ Yes 2 □ No
To B	examiner? 1 ☐ Yes 2 X No	Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3	Othori		
ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28c. Injury at Work? 1 Yes 2 No	28d. Describe ho	w injury occurred
Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At home, farm, street, fa building, etc. (Specify)	actory, office	28f. Location (Str City or Town,	reet and Number or Rural Route Number, State)
Medical (29a. Certifier (check only one) 1 Certifying Phy 2 Medical Exam	sician: To the best of my knowledge, death occi niner: On the basis of examination and/or investig and manner stated.	urred at the time, date and place pation, in my opinion, death occu	e, and due to the caurred at the time, da	ause(s) and manner as stated. ate and place, and due to the cause(s)
ž	29b. Signature and title of certifier		29c. License number	29	d. Date signed (Month, Day, Year)

D0043577

November

600 North Wolfe St, Baltimore, MD, 21287

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lawrence Mark Nogee

31. Date filed (Month, Day, Year) NOV 1 9 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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-	Medic Examin		4a. Facility Name (if not institution		mber)		4b. City, Tov	wn orl	ocation o	of Death	Month Novembe		2010 County of Dea	10:30 a M	_
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	Funeral Director		5. Social Security Number 219–12–4259	6. Sex 1 M 2 F	7. Age (In yrs. I	last birthday) Yrs.	If Under 1 \ Months D		If Under 2 Hours		8. Date of Birth (Month, Day May 18,	h	9. Bir	rthplace (State or Foreign ountry) MD	_
	nd how at	5	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Loc	cation							10d. Inside City Limits	_
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	th with ms 23 must	Funeral	1151 Carrs Whard				21037					USA	<u> </u>		
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Baltimore, Maryland 21215-0036	hin 7	Completed		ent's Education est grade completed College (1		(Give k life. DC	lent's Usual O kind of work d O NOT use ret Omemaker	lone dui tired)		of working	7		d of Business	Industry	
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timore	t. Page 1 au tment of H tant: If iter ijury or oth		20a. Method of Disposition 1 ☑ Burlal 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State C	Place of Dispos cemetery, crem chington	natory or other	r place)		Nov. 20			ation - City or land, MI		
Bal	permit. Page Department of Important: If any injury or	- 1	21. Signature of Funeral Service I	2 Door	کر	500 500	Name and A rnacis J Univers	sity	Blvd.	. W.,	al Home Silver S	pring,	,MD 2090)1	1
~	h sician/	E /	23a. Part 1. Inter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition	only one cause on ea	caused the death ach line. cimer's De		r the mode of	dying,	such as c	ardiac or r	respiratory arre	st,		Approximate Interval Between Onset and Death 3-4 vrs	-
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36516 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Barbara G. Radcliff 12:20am 2010 November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗶 F Days Hours Months 01/09/1923 Yrs Director 721-03-6211 87 Washington. Usual Residence of Decedent 10b. County or 28a-f show 10a State with the Maryland r than "natural", or items 23a or 28a-f sho the Me rical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11703 Lytle Street 20902 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ğ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary U.S. Government 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Harvey Martin Middlekauff Murtle K. Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Caroline L. Diehl - Daughter 1263 Donegal Springs Road, Mount Joy, PA 17552 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 D Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 11/04/2010 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. Anne Marie 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Heart Failure disease or condition Medical resulting in death) **Examiner** Aspiration Pneumonia Sequentially list conditions, Examiner If any leading to in mediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of deliven 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death Unknown Day 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ♣No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 1 No 1 Expatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Watural 5 Pending work? Division 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) Medical 29a Certifier Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge 29b. Signature and title of certifier 29c. License number 66264 29d. Date signed (Month, Day, Year) /4///10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Babak Salehi Pirouz.

B1. Date filed (Month, Day, Year)

8600 Old Georgetown Road, Bethesda, Maryland 20814

M.D.,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 Randall Leslie Noyes November 12:51 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Dove House Westminster Carroll 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Oct 16, 1 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 😿 F Months Days Hours Min Yrs Director 025-52-3463 1958 Massachusetts Usual Residence of Decede 28a-f shov 10b. County at 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Examiner must be notified 1 Yes 2 KNo Maryland Carroll Westminster 9 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 23a Funeral 1020 Poole Road 21157 United States items . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S Race - American Indian, Black, White, etc. Armed Force 5 ò 1 Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No If Yes, Give 21215-0036 1 ☐ Yes 2 ☐ No Specify: "natural" Completed 3 Widowed 4 Divorced Year or Dates White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Trainer Horses Be filed 17. Father's Name (First, Middle, Last) Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Sumame) ည Page 1 and 2 should be Robert Noves Randall Dawn Vickery Weathersby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Ashton Compton/Partner 1020 Poole Road Westminster, Maryland 21157 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 11/4/2010 Woodbine, Maryland 21. Sign ture of Funeral Service Licer Soing Home Cremation Service P.O. Box 784 M00957 Heckrotte, P.A. Clarksville, MD 21029 23a. Part L'Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, it arry, leading to immediate cause. Enter Underlying Examiner Due to (or de a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last Physician: The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 month 5 Other (specify) Month Pregnant at time of death the Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed? Yes 2 No this certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital: 2 ₩ No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 Prother (Specify) IN PATIENT မ 1 Inpatient 2 I ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at MOSTICE 28d. Describe how injury occurred **Hospital or Attending** 1 Natural 2 Accident work? injury 5 Pending Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

Registrar

egistrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

hrute mo

05 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of I	Maryland /				and N	lental Hy	giene	0.0	. ^	~ ~ ~ ~
			State Registrar			Certi	ficate of L	Death			Reg. No	20	10	<u> 365 8</u>
	Physicia	an/	Decedent's Name (First, Middle	e, Last)						2. Date of Dea Month	ath Da	v	Year	3. Time of Death
	Medi	cal	Shirley 4a. Facility Name (if not institution	A.	Ro1f					Novembe	r	2 2	010	3:14 A M
T	Examir	ier	112 West Pear		,	4	b. City, Town, or Rising		of Death		40	. County o		
	Funeral	Г	5. Social Security Number	6. Sex 7. /	Age (In yrs. last bi		f Under 1 Year	If Under		8. Date of Birt	h	Cec		lace (State or Foreign
	Director		213-52-8013	1 □ M 2 □ X €	69	Yrs.	flonths Days	Hours	Min.	Mar. 6,	^{v,} 192	1	Count	PA
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	arylar a-fsl	ecto	MD Cecil			ng Su							- ["	Od. Inside City Limits 1 X Yes 2 No
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36	after Il", or xamil	d by	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	ried 1 Tyes 2 If Yes, Give	X No	1	Yes 2 XNo			rilodii, ctc.)	- 1	Black Specify:	White, e	
9	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed		Year or Dates.			t's Usual Occup				101 16		Whi	
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pu	should be filed within 7 n and Mental Hygiene. 7 is marked other than raumatic event, the M	To Be	17. Father's Name (First, Middle, I	Ť				18. Mothe	er's Name	e (First, Middle,	Maiden	Surname)		
2	uld by d Mer mark natic		Maurice S. Tho						sy B					
Maryland 21215-0036	2 sho Ith and 27 is u		19a. Informant's Name/Relations Richard Rolfe	1-1-37	ı		Address (Street &						te, Zip C	ode)
ē,	1 and 2 should be filed within 72 hour if Health and Mental Hygiene. item 27 is marked other than "natu other traumatic event, the Medical		20a. Method of Disposition		20b. Place	of Disposition	Box 295 on (Name of	KISI		un, MD		L ocation - C	ity or Toy	vn State
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Baltimore,	permit. Page 1 and 2 sl Department of Health a Important: If item 27 is any injury or other tra		21. Signal Funeral Service L		Diace				<u> </u>	7/2010	рет	ta,	rA	
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			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that caus only one cause on each li	ed the death. Do ine.	not enter th	e mode of dying	g, such as	cardiac o	r respiratory arre	est,			Approximate Interval Between
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68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical		d									\perp	
687	eath certifica attending p	Ž	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregnancy					-				
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Division of Vital Records,	r Atte ter de recto	Certificate:	3 Suicide 6 Could r 4 Homicide determi	not be 28e. Place of In	njury - At home, fa etc. (Specify)	arm, street,	factory, office		2	28f. Location (St		Number	or Rural F	Route Number,
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	To the Hospital or Attent within 24 hours after deat To the Funeral Director: completed filled in by the	Medical	(Uneck Z L Medical E)	Physician: To the best of xaminer: On the basis of	examination and/o	or investidati	on. In my opinior	n, death occ	curred at f	the time date an	d place	and due to	the caus	e(s) and manner stated
	omple		only one) 3 L Certifying 29b. Signature and title of certifier	Nurse Practioner: To the	e best of my know	/ledge, death	29c. License		and place			and mann signed (/		
	F > F 0		1 Western	Ano			P664		2	-	.su. Date	. 1	1	
	4		30. Name and address of person		death (Item 23a) ((Type, Print)		111	7_			1-	1 20	16
	/		Joseph K. Weid	ner, MD 101	Colonia	1 Way	Rising	Sun,	MD	21911				
	State Registra	-	31. Date filed (Month, Day, Year)	32. Regist	rar's Signature	9 160	wes							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year KEIKO ONODERA ROONEY Medical VOVEMBER 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK . Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days 1 □ M 2 🛛 F Months Hours Min. Country) Director Yrs 81 215-68-8315 Japan Aug. Usual Residence of Decedent 10a. State 10b. County within 72 hours after death with the Maryland Ħ Director 10c. City, Town or Location 10d. Inside City Limits or 28a-f s notified 1 🗌 Yes 2 💢 No Maryland | Montgomery Gaithersburg ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o edical Examiner must be Funeral 23509 Rolling Fork Way 20882 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Yes 2 🛣 No If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Specify. Completed Japanese Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jungo Onodera Yaeko Saijo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12116 Stardrift Drive, Germantown, Maryland Patrick J. Rooney - Son 20876 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arlington National 12/10/10 Arlington, Virginia 22. Name and Address of Facility
Molesworth-Williams P.A., Funeral Home 21. Signat re of Fun ral Service Lig Ridge Road, Damascus, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death - Ph. sician/ 122001 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence or). attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed 040 that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year has I een signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≦ 5600 Completed 1 🗷 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 🔀 No this certilicate 2 🗌 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 X No Other: 잍 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) : After this funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending work?
1 Yes 2 No neral Director: A filled in by the fu ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hin 24 hours a the Funeral C mpleted filled Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MDD 14626 11/3/10

Registrar
DHMH 17 Rev 7/2009

State

501 W 74h

32. Registrar's Signature

Ensura

5+

Frederick, mo 21701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rausch

Gregory

NOV

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October Ruth McKay Scott 2010 8:00p Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Absolute Assisted Living Facilities Rockville Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country) Illinois 1 □ M 2 🕱 F Months Days Hours Director 85 Yrs. 528-22-4940 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland 1 Yes 2 X No Montgomery Rockville 10e. Street and Number ò 10f. Zip Code er than "natural", or items 23a of the Medical Examiner must be 10g. Citizen of What Country? Funeral 620 Anderson Avenue 20850 U.S.A. hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Yes 2 X No If Yes, Give Year or Dates. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: Caucasian 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 12 should be filed within 72 alth and Mental Hygiene.
27 is marked other than "1 traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Real Estate Agent Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည William Monroe McKay Maralda May Allen 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If Item 27 is 1 any injury or other traumonce. 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Scott Dowler/Daughter 620 Anderson Avenue, Rockville, Maryland 20850 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 11/05/2010 Brentwood, Maryland 21. Signature of Funeral Service Lic-nsee 22. Name and Address of Facility Simple Tribute Funeral & Crem. NO #1070 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Arrhythmia Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ② No Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown this certificate has been ral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Assisted ၉ 1 Tyes 2 🛚 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 V Other (Specify) rvrna s after death.
al Director: After th Certificate: 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred X Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) pleted filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division of Vital Records, P.O. Box 68760 within 24 hours a

Registrar DHMH 17 Rev 7/2009

State

29a. Certifier

29b. Signature and title

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Chablani.

NOV 04 2010

🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D42518

11119 Rockville Pike, #401, Rockville, Maryland 20852

29d, Date signed (Month, Day, Year)

November 03.

2010

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	-	For State Registrar	State of Ma	ai yiai iu		tificate of L		ara ivit	-	Glerie Reg. No	71111	36521
Physicia	n/	Decedent's Name (First, Middle, Lass Rebecca	Schauer	_			-		2. Date of Dea Month October		ay Year	3. Time of Death
Medic Examin		Harriet Rebecca 4a. Facility Name (if not institution, give		-		4b. City, Town, or	r Location of	Death	Ctoper		c. County of Deat	6:30 a M
		Holy Cross Hospital	In .				er Sprin				Montgon	
Funeral Director		5. Social Security Number 578–24–0833 Usual Residence of Decedent	7. Age	(In yrs. last	Yrs.	If Under 1 Year Months Days	If Under 24 Hours		8. Date of Birt (Month Day Dec 15,	th 1924	9. Bird Cod	thplace (State or Foreign untry) NC
Aaryland 8a-f show tified at	rector	10a. State 10b. County MD P.G		10c. City, To								10d. Inside City Limits 1 ☐ Yes 2 ☐ No
with the N s 23a or 2 ust be no	Funeral Director	10e. Street and Number 3160 Gracefield Road	, #1103			10f. Zip Code	20904			10g. Ci	itizen of What Co	untry?
re, Maryland 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mertial Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ρ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Yes 21 If Yes, Give Year or Dates.			Vas Decedent of H Yes, specify Cuba ☐ Yes 2 🛣 No		n? (Speci Puerto Ri	fy Yes or No- can, etc.)		14. Race - Ame Black, White Specify: Whi	e, etc.
Baltimore, Maryland 21215-0036 Permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", o any injury or other traumatic event, the Medical Exam	Completed	15. Decedent's E (Specify only highest gra Elementary/Seconday (0-12)			(Give k life. DC	ent's Usual Occup ind of work done of NOT use retired)		of working	7	16b. K	(ind of Business	Industry
laryland 2 should be filed wit and Mental Hygie is marked other aumatic event, th	0	17. Father's Name (First, Middle, Last) Charlie Moore	2		Secre	tary	18. Mother		First, Middle,	Maiden	,	L MD
e, Mary and 2 should Health and M tem 27 is mar other traumat		19a. Informant's Name/Relationship (7) Raymond C. Schauer/S		1		g Address (Street a 4 Whitesta		or Rural F	Route Number	r, City or	r Town, State, Zip	Code)
Baltimore, M Permit. Page 1 and 2s Department of Health Important: If item 27 any injury or other tr		20a. Method of Disposition 1 120 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		ceme	etery, crem	sition (Name of atory or other plac Memorial Pa		Nov.	4.		ocation - City or	
Balt Depart Import any inj		21. Signature of Funeral Service Licens	ee Oode	i to	Fr. 50	Name and Addres ancis J. O O Universi	of Facility Offins ty Blvd	Funera	al Home Silver	Inc. Spri	ng,MD 2090	01
Physician/ Medical		23a. Part 1. Enter the disease, or composition shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause op each line	MARI	k	r the mode of dying	g, such as ca	ardiac or r	respiratory arr	rest,		Approximate Interval Between Onset and Death
Examiner	her	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a									
xecuted n and al-transit	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	cDue to (or as a								1	
8760 ifficate be executed by physician and as the burial-transit	Medical	C	d									
Box 64 death cert he attendir led for use	€ 1	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of Live Birth 2 A Pregnant at 9 Unknown	2 🗌 Fetal de	eath 3 🔲	Ectopic pregnanc Other (specify)	у				23d. Date of del Month	ivery Day Year
dS, P.O. quires that the an signed by to the detach	ed by PI	Part II. Other significant conditions of					ren in Part I.					the cause of death?
Rec The law ate has	Completed by								24a. Was a autop perfor 1 Yes	rmed?	prior to death?	opsy findings available completion of cause of 2 🏻 No
/ital	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	nt 2 🗆 ED/	Outpotiont	Otho	ace of Death					
on of vinding Phy ath.		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injur (Month, Day,	y 28t	b. Time of injury	28c. Injury work	at	28	d. Describe h		S ☐ Other (Speci y occurred	T/)
DIVISION TENDINATE TAN ARTER AN ANTER AN ANTER AN ANTER AND ANTER AND ANTER AN	_	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.		, farm, stree	et, factory, office		28	f. Location (S City or Tow			al Route Number,
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completed filled in by the funeral director,	Medica	(Check 2 Medical Exami only one) 3 Certifying Nurs	ician: To the best of r ner: On the basis of ex e Practioner: To the b	amination and	d/or investig	gation, in my opinio eath occurred at the	n, death occu time, date ar	urred at th	e time, date ar	nd place	, and due to the o	ause(s) and manner stated.
5 With		29b. Signature and title of certifier	1			29c. License	number 103)		;	29d. Da	te signed (Month $2/0$, Day, Year)
-		30. Name and address of person who c Eugenio Machado, MD	ompleted cause of de 3110 Grace	ath (Item 23a efield I	a) (Type, Pr Road,	Silver Spr	ing,MD 2	20904				
State Registra	-	31. Date filed (Month, Day, Year)	37. Registrar	's Signature	pou	S.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ John Calvin Schaeffer October 2010 31 3:20 p Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Care Baltimore Towson 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 **X** M 2 □ F Months Days 218-24-7761 Hours Min. Sep 21, 1928 82 Director Yrs Mary Land Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits notified Maryland 28a-f Carroll Westminster 1 Yes 2 No 10e. Street and Number ö 10f. Zip Code 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be 10g. Citizen of What Country? Funeral 316 Hilltop Drive 21158 USA death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ģ 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Banking President/CEO Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည William E. Schaeffer Mary K. Bankert and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh Iment of Health a tant: If item 27 is Evelyn Schaeffer, wife 316 Hilltop Drive, Westminster, MD 21158 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 s
Department of IImportant: If ite
any injury or ot 20c. Location - City or Town, State 1 KBurial 2 Cremation 3 Removal from State St. Mary's Cemetery 4 Donation 5 Other (Specify) 11/4/2010 Silver Run, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 tar 28a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (as a consequence of) Examiner wezlis D. Hru Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) death certificate be executed tran Due to (or as a consequence of): resulting in death) Last the burial ttending physiciar Physician/Medical Box 68760 as IF FEMALE: or use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Pregnant at time of death Month signed by the Yes 2 No g Unknown 9 Unknown To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Certificate: To 2 No Other: 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Division of Vital Records, P.O. 29b. Signature and title of certifier WJL 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LAMES MO 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar DHMH 17 Rev 7/2009 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Items 25,27,28a-f per me 9909 11/19/2010dhb
Reg, No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Sept. 23 ay 4:00P M Physician/ William Smith 2010 Christopher Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Hagerstown 16947 Shadybrook Terrace If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Min. Days 1 X M 2 □ F Hours Maruland Director 219-92-7445 arch Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f shor Director notified 1 ☐ Yes 2 ☐√No Μđ Washington Hagerstown 10f. Zip Code 10q. Citizen of What Country? 10e Street and Number Funeral items 23a U.S.A must 21740 16947 Shadybrook Terrace death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, the Medical Ex miner Armed Forces? Black, White, etc "natural", or þ 1 Never Married 2 Married Maryland 21215-0036 72 hours after 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates Specify. White Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Health Services Behavior Specialist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental His marked of permit. Page 1 and 2 should be fili.
Department of Health and Mental
Important: If item 27 is marked of any injury or other traumatic eve ပ Patricia A. McLemore John W. Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 16947 Shadybrook Terrace Hagerstown, Md. 21740 Patricia Litty (Mother) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Sept. 25, Smithsburg, Md. Smithsburg Crematory 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. MO1414 J.L. Davis Funeral Home Smithsburg, Md. 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Deymonia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of) Examin physician and s the burial-transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown odumatic Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be irector, page 2 s autopsy 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ပ္ this 28d. Describe how injury occurred **Subject**operator of a bicycle
collided with on SUV 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 11:25 a M Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 🗶 No 05/29/2010 within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Investigation Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1200 Pennsylvania
Ave., Hagerstown, MD determined Parking Lot Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signa are and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) -24-2010 D60417 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) tredevice 21707 Thomas Tehnson 65 Shah 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36524 For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last, 2 Date of Death 3. Time of Death Stecko Month 0821 Physician/ Year 0 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner General olumbia If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Months 1 M 2 W Director Usual Residence of Decedent shov 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits any injury or other traumatic event, the Medical Examiner must be notified at Director items 23a or 28a-f 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian Black, White, etc. "natural", or 1 Never Married 2 Married Completed by 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ₩ Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnar Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 shou Department of Health and Important: If item 27 is m 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition Date 1 Burial 2 remation 3 Removal from State Other (Specify) 21 Signature of art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirat my arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 month Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, arcinoma 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes 2 b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗀 No ☐ Yes 1 Tyes 2 [within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 **1** No 1 🗌 Inpatient 2 R/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Watural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific NIL 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7800

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

Reg

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Year Seabrease Vivian L. 2010 2:03a. 26 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Hampstead 4c. County of Death Carroll **Examiner** Golden Crest Assisted Living 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days (Month, Day, Year) 1 □ M 2 🛣 F Yrs Director 475-09-6819 95 30 July WT Usual Residence of Decedent 28a-f show 10b. County at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 🗌 Yes 2 🔀 No Baltimore MD Upperco 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 16776 Gorsuch Mill Road USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 0 þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white 'natural" Completed 3 XWidowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) the 12 homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve မ Hialmar Johnson Laura Amundson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol S. Warner, daughter 16815 Falls Rd., Upperco, Md. 21155 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Nurial 2 Cremation 3 Removal from State 10/28/10 Moreland Memorial Baltimore, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eline Funeral Home M00741 Hampstead, Maryland 21074 934 S. Main St. Lemmer 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final engentre Physician/ disease or condition resulting in death) Medical Due to (or sonsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence on Exami hysician and the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Pregnant at time of death 9 Unknown g Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law autopsy page 1 ☐ Yes 2 EKNo Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specify) ssisted Hospital: 2 1 No Other: 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA After this <u>Living</u> 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No s after death. ☐ Accident ☐ Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined 24 hours Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) WJL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) F. Vento, M.D., 114 Business Center Drive, Reisterstown, Md. 31. Date filed (Month, Day, Year) 32, Registrar's Signature State Registrar

Box 68760

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October Ruby Anderson Patterson Spearman 2010 1:35 а м Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 M 2 X F Min. Dec. 23, Year) 928 Virginia 218-22-9330 81 Yrs. Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Maryland Cecil Conowingo 1 Tes 2 No ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a with 104 Skyline Drive 21918 U.S.A. Items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 should be filed within 72 hours after the and Mental Hygiene.
27 is marked other than "natural", traumatic event, the Medical Exal 1 Yes 2 No Specify: If Yes, Give White Completed 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Personal Residence Twelve Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Deedie Dan Anderson Carrie Lou Spencer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Douglas Erps 104 Skyline Drive, Conowingo, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mark's Cemetery Perryville, Maryland 11/04/10 Name and Address of Facility ee A. Patterson & Son Funeral Home, 21. Signature of Funeral Service Licens Perryville, Maryland 21903-0766 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CHRONIC OBSTRUCTIVE PULMONARY DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year Pregnant at time of death been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has in funeral director, page 2 s autopsy e Hospital or Attending Physician: The I 24 hours after death.
e Funeral Director: After this certificate heleted filled in by the funeral director, page performed Yes 2 X No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Tes 2 X No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the within 2 To the I 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 2010

State Registrar JACKIE JONES,

31 Date filed (Month, Day Yea,

CRNP

1:35

2010

30,

OCTOBER

RUBY SPEARMAN

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Willa Loudell Stockman November 2010 5:20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10015 New Bridge Road Denton Caroline 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country)
Maryland (Month, Day, Yea Months Davs Hours Min. Director 220-36-6123 March Usual Residence of Decedent permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he mattered at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State Director 1 🗆 Yes 2 ី No Maryland Caroline Denton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 10015 New Bridge Road 21629 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? by 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Completed 3 Divorced 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Health Caregiver 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jennie Catherine Bickford Willard Elmon Otto, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank K. Stockman/spouse 10015 New Bridge Road, Denton, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Nov. 13,2010 4 Donation 5 Other (Specify) Capitol Crematory Dover, Delaware 22. Name and Address of Facility Moore Funeral Home, P.A. . Signature of Funeral Service Licer 11004 12 South Second Street, Denton, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ mont disease or condition inoma Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): led by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Pregnant at time of death Other (specify) g 🗌 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 has 1 ☐ Yes 2 ☐ No To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 XNO 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

within 24 hours after death.

To the Funeral Director: After this certificate filled in by the funeral director, the Hospital completed

> State Registrar

DHMH 17 Rev 7/2009

Medical

31. Date filed (Month, Day, Year) 12 NOV

determined

4 Homicide

only one) 29b. Signature and title of certifier

29a. Certifier

ld Registrar's Signat

Spg Idlewild

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year)

2010

21601

MI

City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 1 C 26 Day Physician/ PM ZO IO Tucker Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Travma Hospita Himor If Under 1 Year | If Under 24 Hrs 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min Months Hours 10-02-1966 Mary Land 1 x M 2 □ F Director 44 216-02-0681 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location **Funeral Director** notified 1 🌠 Yes 2 □ No North Beach MD Calvert 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe ò be 23a USA 20714 3902 4th Street items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Force ö Completed by 1 Never Married 2 Married 2 X No Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: "natural" 3 Widowed 4 X Divorced white Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than Elementary/Seconday (0-12) College (1-4 or 5+) I Hygiene. the Printing 11 Printer traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) is marked ၉ Patricia Victoria Arno1d Tucker Sr Vernon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health tem 27 20678 4010 Sixes Road, Prince Frederick, \underline{MD} Kristin Tucker Buckmaster daughter other 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot once. cemetery, crematory or other place, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-09-2010 Friendship, MD Friendship Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Regulia of Mathers Landing Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) **Hospital or Attending Physician:** The law requires that the death certificate be execut**e**d 24 hours after death. as the burial-tran and resulting in death) Last Due to (or as a consequence of) physician Completed by Physician/Medical Box 68760 CERTIFICATION. IF FEMALE: nse s 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day ίó Pregnant at time of death 2 No the 9 Unknown Unknown P.O. cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes Records, 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? performed? Yes 2 No 1 Yes 2 No certificate **Division of Vital** funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 0630 m 5 Pending inhalation of exhaust 2 No 10/26/2010 2 ☐ Accident 3 ☑ Suicide Investigation the 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide completed filled in by determined 3902 4th St. North Beach MD nome Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse_Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year)

State Registrar

Signature and title of certifie

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22

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar Signature

DHMH 17 Rev 7/2009

2010

Samontha wood mo

21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Terrism 06024M Medical sher of OVA 2 DILO 4a. Facility Name (if not institution, give street and number Examiner City. Town, or Location of Death 4c. County of Death Mostgomes Rockvill If Unde 5. Social Security Number 6 Sex ast birthday) Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 ₩ M 2 □ F Months Hours Min. Director 503-44-9147 20 1940 Wisconsin 70 Mar Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 XYes 2 ☐ No Maryland Frederick Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 335 W. Main Street 21788 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes, Give 2 No Maryland 21215-0036 "natural", 3 XWidowed 4 ☐ Divorced 1 ☐ Yes 2 X No Specify: Completed Year or Dates.1959-62 Specify: White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 the Road Truck Driver Trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Walter C. Jensen Clarice Chamberland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sonija Marie Gierman/daughter 6450 82nd Avenue N. Pinellas Park, Florida 33781 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ò cemetery, crematory or other place, injury Journey Crematory 11/4/2010 Woodbine, Maryland 21. Sign twee of Funeral Service Lice Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M uanto M00957 MD 21029 23a. Partt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ C disease or condition resulting in death) 054 Medical Due to (or as a consequence of) Examiner ASTA Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of that the death certificate be executed burial-transi moli cation that initiated events resulting in death) Last Due to (or as a consequence of): has been signed by the attending physician je 2 should be detached for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant 9 Unknown Pregnant at time of death Month 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Hospital or Attending Physician; The law requires 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? After this certificate 1 ☐ Yes 2 ☐ No ☐ Yes director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

Yes Hospital 2 \ No Other: ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending ☐ Accident☐ Suicide Investigation
6 Could not be 1 Tes 2 No within 24 hours after deat To the Funeral Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Number Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 L 29b. Signature and title 29d. Date signed (Month, Day, Year) Normbe 2010 30. Name and address of person wi ompleted cause of death (Item 23a) (Type, Print) 8+ 9909 10 31. Date filed (Mon 32. Registrar's Signature State 2010 5

DHMH 17 Rev 7/2009

Registrar

W. St. And

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 36530 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 37, 20 TO 0045 Sandra Hill Trundle Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carroll 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗙 F Sep 23, Year 943 67 Mary land Yrs Director 216-38-3165 Usual Residence of Decedent 28a-f show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Westminster Carroll 1 X Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 Funeral 104 Pine Valley Court USA 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced white Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed, 16b. Kind of Business Industry 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Home 12 Receptionist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Willard F. Hill Mary Edna Stack permit, Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 Pine Valley Court, Westminster, MD 21157 Patricia J. Richards, sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Septem crematory or other place) 11/03/2010 4 ☐ Donation 5 ☐ Other (Specify) Winfield, MD Carroll Crematory 2. Name and Address of Facility Myers-Durboraw Funeral 91 Willis Street, Westminster, MD 21157 Signature of Funeral Service Licenses 22. Name and Address of Facility Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ntracrama disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day 1 ☐ Yes 2 ☐ 9 ☐ Unknown been signed by the should be detached 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ M455 Completed I ntracranial Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an cate has t page 2 s autopsy performed this certificate Yes 2 N To the Hospital or Attending Physician: 1 within 24 hours after death. To the Funeral Director: After this certifics 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 Tyes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer injury 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DHMH 17 Rev 7/2009

State Registrar

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

NOV 0

and address of person who completed cause of death (Item 23a) (Type, Print)

Hosain

MD

32. Registrar's Signature

39502

East Main st. Westwinste

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October Dorothy K. Volk 2 0 1 0 12:0701 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3330 N. Leisure World Blvd., Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 9. Birthplace (State or Foreign Months Days (Month, Day, Year) May 01, 1915 Hours Min. Country) Director 401-05-2078 Kentucku Usual Residence of Decedent 28a-f show "natural", or items 23a or 28a-f shovedical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits Maryland Montgomeru Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 3330 N. Leisure World Blvd. #718 20906 U.S.A. 72 hours after death 12. Was Decedent Ever in U.S. 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 Divorced Specify Caucasian event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper Private Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ Samuel Kaufman Rose Wasbutsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Volk Freedman/Daughter 17774 Chipping Court, Olney, Maryland 20832 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ing David Mem. Grdns 11/01/2010 | Fall Church. VA 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Vetu 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Chronic Cardiovascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 X No Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed? 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 💢 No မ Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1 🕱 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State 29a. Certifier 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 | only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 5 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) D0063195 October 31. 2010

Registrar

State

Rockville. Maryland 20850

Piccard Drive.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1355

M.D.,

Year

MOV 03

Steven Wilks,

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of M	arylanc		artment of I <i>rtificate of I</i>		-	giene Reg. No.2	010	36532
	Division		1. Decedent's Name (First, Middle, La	st)					2. Date of De	ath	3 1 0	3. Time of Death
	Physicia Medi		Ralph Robe	ert Vande	erlipp)			Novemb	er 3,	2010	5:25 A M
	Examir	ner	4a. Facility Name (if not institution, give					r Location of Death	1	4c. Cour	nty of Death	
	Fig. 1991		Gilchrist Hospic 5. Social Security Number 6.3		e (In yrs. las	4 h leth elovi	Towso		Table (a)		Balti	
	Funeral Director			X M 2 □ F	83	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da Jan 9,	y, Year) 1927	9. Birth Cour	place (State or Foreign htry) Jersey
	D W		Usual Residence of Decedent		- 3				Todii 5,	1221	1 IVEW	Dersey
	ryland I-f sh ied a	ē				Town or Lo						10d. Inside City Limits
	ne Ma or 28a notif	Director	Maryland Howard 10e. Street and Number			Colum	10f. Zip Code		— т	10 000		1 Yes 2 No
	with t	Funeral	9310 Old Line Dr	rive				21045		10g. Citizen o	ited S	•
	death items ier mi	표	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. \	Vas Decedent of H	ispanic Origin? (Sp	ecify Yes or No-		ace - Americ	
36	filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ğ	1 Never Married 2 Married	1 Yes 2	No O 4:4		f Yes, specify Cuba		Hican, etc.)		lack, White,	etc.
21215-0036	nours natura ical E	Completed	3 Widowed 4 Divorced	Year or Dates.	944-4	:0	lent's Usual Occup			Speci	W	hite
215	in 72 ł e. nan "n Medi	dmo	(Specify only highest gr Elementary/Seconday (0-12)			(Give I	kind of work done of O NOT use retired)		ding	16b. Kind of	Business In	dustry
7	d with ygien her th			4	''	Ele	ctrical 1	Ingineer		Elec	ctroni	cs
Maryland	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last)					18. Mother's Nam			,	
Ž	ould b	Ĺ	Nathan Floyd 19a. Informant's Name/Relationship (7)	Vanderli	.pp			Edla	Alber		Carls	
	of and 2 should be file of Health and Mental F fitem 27 is marked of rother traumatic even		Janet E. Vanderl		1		g Address (Street a					
e,	of Hez of Hez fitem rothe		20a. Method of Disposition		20b. Plac	ce of Dispos	sition (Name of		Columbia Date	20c. Location		
Ĕ	Page 1 ment of ant: If it ury or o		1 Burial 2 Cremation 3 4 Donation 5 Other (Special	Removal from State (y)			natory or other place ney Crema		5/2010	Woodbi	ne. M	aryland
Baltimore,	permit, Page 1 Department of Important; If it any injury or conce.		21. Sig are of Funeral Service Licent	0-		G 22	Name and Addres	is of Facility Crematio	n Servi	ce P.O.	Box	784
H			23a. Part Enter the disease, or com shock, or heart failure. List only o	olications that caused	the death.	Do not ente	r the mode of dying	g, such as cardiac	e, P.A. or respiratory arm	est,	VIIIe	MD 21029 Approximate
	Ph sician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Lyu		mA					-	Interval Between Onset and Death
	Examiner	-i-	Sequentially list conditions,	Due to (1 r as a								`
	red nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a	Consequen	ille Oi):						
	eath certificate be executed attending physician and for use as the burial-transit		that initiated events resulting in death) Last	Due to (or as a	consequen	ice of):						
20	tte be hysicia he bul	edical		d								
00	artifica ding pl		IF FEMALE:	00-16	,							
XOC	In the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use an	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of 1 ☐ Live Birth 2 4 ☐ Pregnant at	≥ ∐ Fetal d	eath 3 📙	Ectopic pregnance Other (specify)	<i>y</i>			ate of delive	ry Day Year
	r requires that the de been signed by the s should be detached	hysi	9 Unknown	9 🗆 Unknown			(5,550,13)					
	s that gned be	þ	Part II. Other significant conditions co	ntributing to death bu	t not resulti	ng in the ur	derlying cause give	en in Part I.	23e. Did to	bacco use con	tribute to th	e cause of death?
<u>ה</u>	equire een si nould	eted							1 🗆 Y	′es 2 □ No	3 🗆 Prob	ably 4 Unknown
ecords,	has b	Completed							24a. Was a autop:	sy	prior to cor	sy findings available npletion of cause of
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	ysicia s certi directo	To Be	examiner?	Hospital: 1 ☐ Inpatie		Outpotions	Otho	ce of Death (Check		. 4	·	hospip
5	ng Phy ter thi neral o		27. Manner of Death 1 \(\sum_{\text{N}} \) Natural 5 \(\sum_{\text{Pending}} \)	28a. Date of injury (Month, Day,	28	b. Time of injury	28c. Injury		me 5 L. Reside 28d. Describe ho		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	102/1200
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2	or At after c Direct in by	l G	4 Homicide determined	28e. Place of Injur building, etc.		, farm, stree	et, factory, office		28f. Location (St City or Towr		er or Rural i	Route Number,
ָנ	Spital neral filled	g	29a. Certifier 1/2 Certifying Phys	ician: To the best of n	ny knowledo	ne. death oc	cured at the time	date and place an	d due to the cau	se(s) and man	or so states	
	in 24 he Fu he Fu	Medical	(Uneck 2 Medical Examil	ner: On the basis of exa e Practioner: To the b	amination an	id/or investi	ation, in my opinior	 death occurred at 	the time date an	d place and du	in to the call	co/c) and manner stated
ı	Not To	1	29b. Signature and title of certifier	^~			29c. License	number	2	9d. Date signe	ed (Month, D	ay, Year)
		-	100	,				303	/	Vorcey 5	43	010
15	st		30. Name and address of person who co	ompleted cause of dea	ath (Item 23	a) (Type, Pri	- Charl	es ST	Jan -	SON 1	10	1
	State Registra	-	31. Date filed (Month NOV a) 5 2	010 32. Aggistrar	s Signature	1. 16	ake				-	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Catherine S. Valentine November 06:10 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Calvert Manor Healthcare Center Rising Sun Ceci1 8. Date of Birth (Month, Day, Year) Aug. 14,1917 Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 1 □ M 2**XX**F Months Hours Director Yrs Alburg Vermont 042-20-4145 93 Usual Residence of Decedent show 10a. State 10b. County traumatic event, the Medical Examiner must be notified at 10c, City, Town or Location Director 10d. Inside City Limits 28a-f Maryland Cecil 1 Yes 2 Rising Sun ò 10e. Street and Number 10g. Citizen of What Country? 23a by Funeral 1881 Telegraph Road United States items should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces? Black, White, etc. ō 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Completed 3XXWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) during most of working Il Hygiene. Aircraft Engine Elementary/Seconday (0-12) College (1-4 or 5+) 12 Office Worker Manufacturer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental I ည Joseph Surprise Mary Unknown and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sl ment of Health a tant: If item 27 is Jean Chipman / Daughter 520 South Main Street, North East, Maryland 21901 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or ot 20c. Location - City or Town, State November 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mayerdale Crematory | 6, 2010 Newark, Delaware 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ rementa disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, I any leading to in module cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a obnesquence of Exami Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) attending physician for use as the burial Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Day Year the. signed by to be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Ş Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed? this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 2 🗖 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at After 28d. Describe how injury occurred 1 Natural 5 Pending injury 24 hours after death. Funeral Director: A Accident Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 3 [within 2 To the I only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 11. 5.2010. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S-S SACHDEV MD 126 A. E High ECKEN MO 21921. 5 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar 36534 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 0 Haze1 Johnson Ward 30 2010 10:55 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Calvert Memorial Hospital Prince Frederick Calvert 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 1 □ M 2 🕅 F Months Days Hours Min. 90 212-36-2845 12-03-1919 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 □Yes 2 No Anne Arundel Friendship 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6809 Old Solomons Island Road 20758 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 1√2 Widowed 4 □ Divorced white 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Herbert Johnson, Sr. Malvina Virginia Knight 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geoffrey J. Ward, 6809 Old Solomons Island Road, Friendship, MD 20758 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Metropolitan Crematory 11-02-10 | Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cordio Vasuslava di regse ardio vasculas clizease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due o (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) 2 🐼 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 1 No Anceemia 1 ☐ Yes 2 ☐ No 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No

burial-transi P.O. Box 68760, physician the attending p been signed by the should be detached of Vital Records, has certificate within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, al or Attending I Division

Examiner

Physician

/Medical

Examiner

Funeral

Director

ns 23a or 28a-f sho

Department of Health and Mental Hygiene. Impurs attel of Impurs and Mental Hygiene. In procram: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Evanture, once. Pages 1 and 2 should be filed within 72 hours after

Physician

/Medical **Examiner**

Saltimore, Maryland 21215-0036

Director

Funeral

þ

Completed

æ ျှ MD

death with the Maryland

Physician/Medical ģ Completed Be P Certification: Medical

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 ☐ Accident

3 ☐ Suicide

29a, Certifier

(Check only one)

6 ☐ Could not be 4 ☐ Homicide

and manner stated

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier sur una.

29c. License number D 50653

AYAN C. SUrana

29d. Date signed (Month, Day, Year) 11-1-2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Deale 851-Church

000

Registrar

Hospital

Jew 5

31. Date filed (Month, Day, Year)

32. Registrage Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 29, 2010 Blanche Doris Ward 1:23 а м Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1555 Fowler Road **Owings** Calvert 7. Age (In yrs. last birthday **Funeral** If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 KF Country Hours Min. (Month, Day, Year) July 9, 1932 Director 220-32-6648 78 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at anone. 10a, State 10c. City, Town or Location by Funeral Director 10d. Inside City Limits MD 1 Tyes 2 K No Calvert **Owings** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1555 Fowler Road 20736 USA 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 Yes 2 No If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Divorced Completed Specify **Black** 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Someone Else's Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Ashby Rawlings Sr. Sarah Morsell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Benjamin Ward - husband 1555 Fowler Road, Owings, MD 20736 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Hope UM Church Cemetery November 4, 2010 Sunderland, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sewell Funeral Home, P.A. Deaden 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) Physician Metastatic colon cancer Onset and Death Medical Marthi Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or iinjury Examine Due to (or as a consequence of) e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. و Funeral Director: After this certificate has been signed by the attending a housing made as the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of). the attending physician Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has funeral director, page 2 autopsy performed 1 🗆 Yes 2 🗀 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 1 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending injury

Box 68760 Division of Vital Records, P.O.

Jew) 5

To the Vithin 2

31. Date filed (Month, Day, Year) 32. Registra/s Signature State NOV - 3 2010 Registrar

110 Hospital Road

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

the

completed filled in by

Medical

Accident

3 Suicide
4 Homicide

only one)

29b. Signature and title of certifier

enneth (Abbott

29a. Certifier

Investigation 6 Could not be

determined

Suite 110

Effectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1)56024

Prince Frederick

MD

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

20678

29d. Date signed (Month, Day, Year)

November 2 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Wilfred Augustus Meggie Day 0 1 0 Year Ying Loi Wong aka NOV. 2. 12:27a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice-Casey House Derwood Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Date of Date. (Month, Day, Year) 9. Birthplace (State or Foreign 1 X M 2 🗆 F Months Days Hours Min Country) Jamaica 577-70-5540 **Director** 81 Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County Director 10c. City. Town or Location 10d. Inside City Limits 1 ₹ Yes 2 ₹ No MD Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6709 Michaels Drive 20817 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces Black, White, etc. by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. 1 ☐ Yes 2 → No Specify: 3 Nidowed 4 Divorced Specify: Asian Completed al Hygiene. d other than "natur? event, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Principal Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Sin Hing Wong Jemima Labourer Meggie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roger Wong/Son 15052 Bankfield Drive, Waterford, VΑ 20197 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 6, Nov. Washington Nat'l 4 ☐ Donation 5 ☐ Other (Specify) Cometery 2010 21. Signature of Funeral Service Licensee

22. Name an Address of Facility
Francis J. Collins Fune
500 University Blvd., W

23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 22. Name an Address of Facility Francis J. Collins Funeral Home 500 University Blvd., W., Silver Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) NonHodgkins Lymphoma months Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine e attending physician and and for use as the burial-transit if any, leading to immediate Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Pregnant at time of death 5 Other (specify) Month Year 2 No 9 Unknown Unknown Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. Parkinson's Disease 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' Yes 2 No 1 🗌 Yes 2 🗌 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ★ Other Specify C e ည 1 🗌 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury 2 Accident Investigation 1 Yes 2 No

To the Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 signed by t I be detach has certificate ! After this neral Director: A Medical within 2 To the I

Baltimore, Maryland 21215-0036

-	4 Homicide determined		28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office	28f. Location City or To	(Street and Number or Rural Route Number, own, State)
	29a. Certifier (Check only one)	2 Medical Examiner	an: To the best of my knowledge, death occu r: On the basis of examination and/or investigat Practioner: To the best of my knowledge, death	on, in my opinion, death occurred a	at the time, date	and place, and due to the cause(s) and manner stated
	29b. Signature and title of certifier		29c. License number		29d. Date signed (Month. Day, Year)	

NOV 04 2010

Nov. 2, 2010 D37142

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1355 Piccard Drive, Coleman, Rockville, MD 20855

31. Date filed (Month, Day, Year) State Registrar

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 2¹7, 201 📆 7:50p M Ray W. Weible Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Ceci1 110 Eleanor St. E1kton 5. Social Security Number 6. Sex . Age (In yrs. last birthday, If Under 1 If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min July 31 1 X M 2 - F 506-26-6374 83 Yrs Director NE Usual Residence of Decedent 28a-f shor 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 X Yes 2 □ No DE New Castle Newark 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 100 E. Chestnut Hill Rd. 19713 USA permit. Page 1 and 2 should be filed within 72 hours after death \text{Department of Health and Mental Hygiene.} Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 X Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Locksmith Self Employed Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ၉ Lee Weible Hilda Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phillip Weible / Son 110 Eleanor St. Elkton, MD 21921 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Doherty Funeral Home 11/2/2010 Wilmington, DE 2. Name and Address of Facility Doherty Funeral Homes 3200 Limestone Rd. Wilmington, DE 19808 16 23a. Part J. Enter the disease, or complications that cause the reath. Do not enter the rade of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) **Hospital or Attending Physician:** The law requires that the death certificate be executed 24 hours after death. attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Month Year Pregnant at time of death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached formulated filled in by the funeral director, page 2 should be detached for the funeral director. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify Residence 2 No Certificate: To 1 Tes ER/Outpatient 3 DOA 1 Inpatient 2 I 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certific 29d. Date signed (Nonth, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) 4+1VA 500

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day 3:45 P M Dorothy Porter Williams Oct. 29 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3891 Old Denton Road Caroline Federalsburg If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔯 F 220-12-2118 87 Director 09/04/23 MD Usual Residence of Decedent 10a. State 10b. County show 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director MD Caroline Federalsburg 1 ☐ Yes 2 No 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 2 3891 Old Denton Road Funeral 21632 United States items 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? 1 ∐Yes 2√ No 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or If Yes, Give Year or Dates 1 ☐Yes 2 XNo Specify. White ੬ Specify: 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygien Important: If item 27 is marked other thin any Injury or other traumatic event Seamstress Private Sewing 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Porter Eliza A. Trice ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henrietta Robinson/Niece 26181 Auction Rd., Federalsburg, MD 21632 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Murial 2 Cremation 3 Removal from State 11/02/10 Federalsburg, MD Hill Crest Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home, P.A. Michael Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CARCIN Immediate Cause (Final **Physician** Or OWICHKI disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the as attending IF FEMALE: for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of ocuse of death? 24a. Was an has autopsy certificate perform 2 No 1 ☐ Yes 2 No 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Yes 2. No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 □ No within 24 hours after deatl To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

4/nwood

503

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DRIVE

DHMH 17 Rev 1/2001

ASTON

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Der state of Maryland / Der Registrar	partment of Health and Mental Hygiene 9/2010dhb Prifficate of Death Reg. No. 2 0 1 0 3 6 5 3 9				
			Decedent's Name (First, Middle, Last)	2. Date of Death 3. Time of Death				
	Physicia		LORETTA MAE WEDDLE	Month Day Year October 27, 2010 11:08 PM				
-	Medio Examir		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death 4c. County of Death				
-)		Frederick Memorial Hospital	Frederick Frederick				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign				
	Director		212-62-3442 1 M 2X F 55 Yrs.	Months Days Hours Min. March 7, 1955 Mary Tand				
	d d	_ [Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	To the state of th				
	rylan I-f sh ied a	윉	Maryland Frederick Freder					
	r 282 notif	Director	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?				
	with the 23a cust be	Funeral	6411 Fulmer Road	21703 U.S.A.				
	leath tems er m	틢	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes or No-				
36	", or armin	ģ	1 X Never Married 2 Married 1 Tyes 2 XNo	If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. □ Yes 2 → No Specify: White				
ö	ours a tural	Completed by	3 Widowed 4 Divorced If Yes, Give 1 Yes 2 4 No Specify: Specify: White					
5	72 hc n "na fedic	ם	15. Decedent's Education Classification (Specify only highest grade completed) Elementary (Secondary (1.12) College (1.4 or 5.) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)					
77	vithin iene. or tha	ပ်	Elementary/Seconday (0-12) College (1-4 or 5+) Ne	ver Worked None				
þ	iled v I Hyg othe /ent,	B	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)				
ylar	uld be f Menta narked attic ev	욘	Lee Franklin Weddle	Jenny E. McVey				
, Mar	nd 2 shou ealth and n 27 is rr er traum		Mrs. Jenny E. Weddle, mother 19b. Mai 641	ing Address (Street and Number or Rural Route Number, City or Town State, Zip Code) 1 Fulmer Road, Frederick, MD 21703				
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Mentant: I fitem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 20b. Place of Disposition 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	osition (Name of Date 20c. Location - City or Town, State Mem. Gardens Nov. 2, 2010 Frederick, MD				
Balt	permit. Depart Import any inj once.	3 20	21. Signature of Funeral Service Licensee MO0255	² NReeney and Basford PA Funeral Home 106 East Church St., Frederick, MD 21701				
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between				
	nysician/		Immediate Cause (Final disease or condition Probable	Curum di sordin Onset and Death				
لمبي	Medical Examiner		resulting in death) Due to (or as a consequence of):	8				
		er	Sequentially list conditions, b. Out to or as a consequence of:					
	ed nsit	Examiner	cause. Enter Underlying Cause (Disease or iinjury	1 Au Shall MA				
	icate be executed g physician and is the burial-transit	Exa	that initiated events c. resulting in death) Last Due to (or as a consequence of):	CERTIFICATION APPROVED BY MEDICAL EXAMINER				
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89	certifi inding use a	Š	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	23d. Date of delivery				
P.O. Box 687	e atte	Physician/M	1 103 2 110	Other (specify) Month Day Year				
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<u>o</u> .	s that gned be de	by	Part II. Other significant conditions contributing to death but not resulting in the					
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Ö	law re las be	Completed by		24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of				
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ta	cran: sertifii ector,	Be	25. Was case referred to medical examiner? 1	26. Place of Death (Check only one)				
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0	After After funer	Certificate:	1 Natural 5 Pending (Month, Day, Year) injury	work?				
Sio	deat deat ctor: y the	ij	2 Accident Investigation 3 Suicide 6 Could not be 4 Howkide determined 28e. Place of Injury - At home, farm, st					
Division of Vital Records,	s after		4 ☐ Homicide determined 28e. Place of Injury - At nome, farm, st building, etc. (Specify)	City or Town, State)				
_	4 hour 4 hour Funera ted fille	edical	29a. Certifler 1	occured at the time, date and place, and due to the cause(s) and manner as stated. tigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	To the probptial or Attending Priysician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Me		death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year)				
	- s i ō		Jour MD.	mon 005463(p 10-39-3010				
	,		30. Name and address of person who completed cause of death (Item 23a) (Type,	1.1000				
2			Sued W Haque 700 montel					
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature	e Mail				
	registra		MARK TO SECTION TO THE PARTY OF					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ SCOTT WEAVER Year DONALD 083F Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner REGIONAL HICOMICO TENINSUM SHLISKIL If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 48 vrs 8. Date of Birth **Funeral** 1 M 2 □ F Months Days Min 04-13 8 1962 Delaware Director 221-60-0658 Usual Residence of Decedent or 28a-f shov Director 10a. State 10c. City, Town or Location Seaford traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits Sussex elaware 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 511 State 19973 US 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces Black, White, etc. "natural", or ò 1 Never Married 2 Married Yes 2X No 1 Yes 2 No Specify: white If Yes, Give Specify: 3 ☐ Widowed 4 🖾 Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. life DO NOT use retired)
Mechanic Elementary/Seconday (0-12) College (1-4 or 5+) Auto Repair 18. Mother's Name (First, Middle, Maiden Surname)
Billy Williams 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve Donald M. Weaver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code) 511 State St, Seaford, DE 19973 Donald M. Weaver father 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Hen Topen Mem Pk 11/06/2010 Lewes, DE 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Cranston Funeral Home John A. P O Box_967, Seaford, DE 19973 23a. P. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 27110 CAN Physician/ disease or condition resulting in death) Medical Examiner Direare Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to for as a consequence on physician and s the burial-transit 4997 • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificale has been signed by the attending physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) the hed 9 Unknown ed by t signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Yes 2 L 25. Was case referred to medical exampler?

1 1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: မ 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 I Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6
Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one) 29b. Signature and title of certifier F + 8 F DDD 15 0105 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

DHMH 17 Rev 7/2009

K6006H

ND

31. Date filed (Manth, Day, Year)

800

Registrar's Signature

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BMPGEVIUR

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State of Maryland / Department of Health and Mental Hygiene

		-	For State of Marylan		artment of H <i>tificate of D</i>		lental Hygie Reg.	0010	0.00011
			Decedent's Name (First, Middle, Last)				2. Date of Death	2010	3. Time of Death
	Physicia Medic		Ellen Clare Donahay Yo	ork			Month Novembe	Pay 1,20	10 9:30p ^M
	Examin	er	4a. Facility Name (if not institution, give street and number)			Location of Death		4c. County of De	
			Holy Cross Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. I	last birthday)	Silv If Under 1 Year	er Spri	n g 8. Date of Birth	Montgo	Pirthulana (Ctata as Faraira
	Funeral Director		577-44-8834 1 M 2X F 78	Yrs.	Months Days	Hours Min.	(Month Day Ves	r) 1931	Country) D • C •
	ow t	L	Usual Residence of Decedent 10a. State 10b. County 10c. Cit	ty, Town or Loc	ention				10d. Inside City Limits
	ıryland •-f sh ied at	cto		,					1 Yes 2 No
	or 28s	Dire	MD Howard Co	lumbi	10f. Zip Code	_	10a	. Citizen of What (
	with the 23a can be ast be	Funeral Director	7047 Ivoryhand Place		21045	5		JSA	
	items items er mu	Fun	11. Marital Status 12. Was Decedent Ever in U. Armed Forces?	S. 13. V	Was Decedent of Hi	spanic Origin? (Spe n, Mexican, Puerto I	cify Yes or No-		nerican Indian,
9	after c	by	1 Never Married 2 Married 1 Yes 2 M No		I ☐ Yes 2 🛣 No		i liodii, otoly	Black, Wh	
21215-0036	ours atural	Completed	3 Widowed 4 Divorced Year or Dates.	16a Decec	dent's Usual Occup	ation	161	o. Kind of Busines	
215	ר 72 h ה. an "n Medi	ldm	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	(Give k		during most of worki	ng	s. And of Basines	as madery
21	withii giene er th t, the		2	Sec	retary_			hone C	ompany
Maryland	d be filed Jental Hy Irked oth	To Be	17. Father's Name (First, Middle, Last) William Donahay	18. Mother's Name (First, Middle, Maiden Surname) Ellen Kane					
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental hygiene, ritem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print) Jey York/Son	1	-		Route Number, Cit e, Winds		Zip Code) 1, MD 21244
nore,			1 X Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, crem	esition (Name of matory or other place of Ceme	e) No	v. 8	c. Location - City	
Baltimore,	permit. Page Department of Important: If any injury or once.	1	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	5 ²²	Name and Addres	ss of FacilityFra	ncis J Ivd., We		on, D.C. s Funeral Home In
	482.00		23a. Part 1. Inter the disease, or complications that caused the deat	Si	lver Sp	ring, M	D 20901		Approximate
	the state of		shock, or heart failure. List only one cause on each line.			9,	, , , , , , , , , , , , , , , , , , , ,		Interval Between Onset and Death
Prysician/ Medical			disease or condition resulting in death) Respirator Due to (or as a conseq		lure				1
	Examiner	,	Sequentially list conditions, b. Bilateral	Pleur	al Effu	sions			
	n =0	Examiner	cause. Enter Underlying	uence of					1
	and and	xan	Cause (Disease or iinjury that initiated events c	uence of:					
_	icate be executed physician and sthe burial-transit	edical E	resulting in death) East						
760	icate g phys	l edi	d					1	
Division of Vital Records, P.O. Box 68	iaw requires that the death certificate be executed as been signed by the attending physician and 2.2 should be detached for use as the burial-transi	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of pregnat 1 ☐ Live Birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 🗌	Ectopic pregnand Other (specify)	ey		23d. Date of o	delivery Day Year
Ö	at the		Part II. Other significant conditions contributing to death but not res	sulting in the u	underlying cause giv	ven in Part I.	23e. Did tobac	co use contribute	to the cause of death?
ds, F	quires the	ted by	Diabetes, Hypotension, Cl	lostri	dium Di	fficile	1 ☐ Yes	2 □ No 3 □	Probably 4 😾 Unknown
3ecol	he law re te has be vage 2 sh	Completed	Colitis				24a. Was an autopsy performed	prior t death	autopsy findings available to completion of cause of ? Yes 2 No
ā	sian: T ertifica ctor, p	BeC	25. Was case referred to medical examiner?			ace of Death (Check			
\equiv	hysic this ce al dire	မ	1 Yes 2 X No Hospital: 1 X Inpatient 2			4 LI Nursing Ho	me 5 Residence		ecify)
on of	nding F uth. ; After 1 9 funera	cate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28b. Time of injury	work	yat :? Yes 2 □ No	28d. Describe how i	njury occurred	
Division	al or Atter s after des I Director d in by the	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At he building, etc. (Specif.		eet, factory, office		28f. Location (Stree City or Town, S		Rural Route Number,
_	To the Hospital or Attending Physician: The law Within 24 burus after death. To the Funeral Director Affer this certificate has completed filled in by the funeral director, page 2 s	Medical	29a. Certifier (Check (Check only one) 1 Certifying Physician: To the best of my know only one) 1 Certifying Nurse Practioner: To the best of my know only one)	on and/or invest	tigation, in my opinio	on, death occurred at	the time, date and p	lace, and due to th	ne cause(s) and manner stated.
•	To the comp	2	29b. Signature and title of certifier	2 ,	29c. License		29d.	Date signed (Mo	nth, Day, Year)
J	• (30. Name and address of person who completed cause of death (Iten Yodit Negussie, MD 150	n 23a) (Type, P	est Gle	n Road,	Silver	Spring	, MD 20910
į	Sta [®] Registra		31. Date filed (Month, Day, Year) NOV 0 4 2010	ature	Kal				
	3.0		HUI UZ ZUIU KARANA						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ WEN KE PANG 2212 PM Medical 2010 10 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8600 Suburban Hospital Bethesda Old GEORGETOUN Rd MONFADMEZY Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗙 F 96 Hours (Month, Day, CHINA Director 037-54-3595 02-18-1914 Usual Residence of Decedent 28a-f shov at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits must be notified Macyland Number Bethesas MONTGOMERU 1 Yes 2 No ក 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 23a death with 6916 20817 ChinA 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: ChiNESE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) OWN Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည PANG BING LUAN CHUAN FENG GAO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6916 ARTHUR JING-MIN YANG/SON Bradley Blud. Bethesda, MD, 20817 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 11-02-2010 585 Blackstone Blud. 4 ☐ Donation 5 ☐ Other (Specify) POINT CEMETERY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 5308 Backlich Rd. pringfield 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final PNEUMONIA + Dysician Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner CHRONIC BRONCHITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last that the death certificate be executed Box 68760 22 Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 3 - Ectopic pregnancy 23d. Date of delivery in the past 12 months? 5 Other (specify) Month Year Day 1 Yes 2 No 9 Unknown ate has been signed by the apage 2 should be detached it P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ATHEROSCLEROTIC CARPIONASCHUAR Records, 1 Yes 2 No 3 Probably My Unknown DEMENTIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.
To the Funeral Director: After this certificate I completed filled in by the funeral director, pag performed?

Yes 2 No or Attending Physician: 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \square Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cyrtifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Cyrtifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Cyrtifying Nurse Practioner: (Check 3 29b. Signature and title 29d. Date signed (Month, Day, Year) Mes MD 12657 ss of person who completed cause of death (Item 23a) (Type, Print)

GMIZUS, MD 10605 CONCORD ST. #500 KENSINGTON MD 20845

Registrar

DHMH 17 Rev 7/2009

State

3. Registrar's Signature

MOV 03 2010

0-08816	_	Please Type or Print in Bla				•	_	ible.	0 ([])
arcus E. Brow		State of Maryland / 1-For State	•	ate of Deal		ai Hygie			36543
		Registrar 1. Decedent's Name (First, Middle,Last)	Certino	ale of Deal		2 Da	Req	J. No.	3. Time of Death
Physicia ledical Exami		Marcus E. Brown				No No		Day 17, 2010	1325 hrs
		4a. Facility Name (if not institution, give street and number) University Hospital		4b. City, Baltir	Town, or Location of MORE	Death		4c. County of Death	1
Funeral Director		5. Social Security Number 6. Sex 7. Age (X X M 2 F	(In yrs. last bir	thday) If Und Month Yrs.	der 1 Year If Under hs Days Hours	_	Date of Birth 2 - 0 2 -	Co	thplace (State or Foreign untry) MD
Α.		Usual Residence of Decedent 10a. State 10b. County 11	0c. City, Town	or Longtion					10d. Inside City Limits
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Aaryland 28a-f show at once.	cto	MD NA 10e. Street and Number	Dait	imore 10f. Zij	o Code		10	g. Citizen of What Cou	ntry?
th the Maryland 23a or 28a-f sho notified at once.	Director	334 N. Pulaski Street		2	1223			USA	
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1218 be fill ental H irked	Be	Maurice Brown			Debo			Villiams	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	70	19a. Informant's Name/Relationship (Type, Print) Deborah Williams-Mother					et Ba	er, City or Town, State $altimore$,	MD 21223
re, l s l and f Heal If item		20a, Method of Disposition 1 X Burial 2 Cremation 3 Removal from State	cremat	of Disposition (Na tory or other place)	Date		20c. Location - City or	
Baltimore, permit. Pages 1 at Department of He Important: If ite		4 Donation 5 Other Specify:	Arbu	itus Me	1		00.22	Arbutus,	
Balt permit Depart Impor injury		21. Signature of Funeral Service Licenses		638 N	Address of Facility Gilmor	Wyli Str	e Fur eet l	neral Hom Baltimore	, MD 21217
Physician	- 1	23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.	e death. Do n	ot enter the mode	of dying, such as car	rdiac or resp	ratory arres	st, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Multiple Gunshot Due to (or as a consequence)							Death
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OX 68760, ath certificate be ex attending physician or use as the burial.	O	past 12 months? 4 Pregnant at tin	ne of death	2 Fetal death 5 Other (Spe		pregnancy		IVIOITI	Say Tour
Box he death c y the atten hed for us	Physi	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death b	ut not recultin	ag in the underlying	a cauca aiyan in Bad	i 12	3e Did toh	acco use contribute to	the cause of death?
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of Vig B Physicier this leral di	임	27 Manner of Death 28a Date of Injury	28b.		28c. Injury at Work?		Describe ho	w injury occurred	
ion (tending eath.	ation	1 Natural 5 Pending Nov 17, 2010	123	7 hrs	1 Yes 2	No Subj	ect shot		
O see the property of the prop						; Baltimore, MD			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the built	ပ	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examiners of the basis of examiners on the basis of examiners of examiners on the basis of examiners of e	nowledge, de			ce, and due to	the cause	(s) and manner as stat	ed.
To ct within To ct	Medical	29b. Signature and title of certifier			c. License number		T	29d. Date signed (Mo	
		10-11			O.C.M.E.			November 18, 20	
		30. Name and address of person who completed cause of dea	ith (Item 23a)						
2		Donna M. Vincenti, MD Assistant Medical		111 Penn	Street, Baltimo	re, MD 21	201		
St Regist	ate	31. Date filed (Month, Day, Year) 32. Registrar's	Signature	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		FOR	f Maryland / Depa			ental Hygi	~ ~ ! ~	20511
		1 - State Registrar	Cer	tificate of D	eath		g. No2 U U	36544
Physic	cian	Decedent's Name (First, Middle, Last)	5			Date of Death Month	Day Year	3. Time of Death
	dica	Erven William 4a. Facility Name (if not institution, give street and num	Butt	4b. City, Town, or I	ocation of Death	Novembe:	r 16 2010 4c. County of Dear	
Exam	imei	Northhampton Manor Healt			rederick			derick
Funera	al		7. Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. Bir	thplace (State or Foreign
Directo	or	217-03-9654	92 Yrs.	Wionthia Bays	Tiodis IVIII.	(Month, Day, Y Oct. 28	, 1918 Ma	ryland
and show	,	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation				10d. Inside City Limits
daryla 8a-f s tified	1 2	Maryland Frederick		Th	urmont			1 ☐ Yes 2 🙀 No
the Na or 2	عُ	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Co	ountry?
h with	Funoral Director	14903 Mud College Road			21788			J.S.A.
r deat or iten	الم	11. Marital Status 12. Was Dece Armed For 1 Never Married 2 Married 1 TYes	rces?	Vas Decedent of His Yes, specify Cuban	panic Origin? (Spec , Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
s afte	1	1 Never Married 2 Married 1 XYes 1 X Widowed 4 Divorced 1 Year or Da	9 1	☐ Yes 2 🔀 No	Specify:		Specify:	White
D-UUSO 2 hours after "natural", o	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ent's Usual Occupation	tion uring most of workir	ng 1	6b. Kind of Business	Industry
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Hygie	l a	10 17. Father's Name (First, Middle, Last)	Own	er/operat	18. Mother's Name	(First, Middle, Ma	sheet	necar
Viana d be filed Mental Hy arked oth	Ŀ	Moseby Butt				a Irene 1	-	
Mary 2 should th and N 27 is ma		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street ar	nd Number or Rural	Route Number, C	ity or Town, State, Zi	p Code)
e, IV and 2 s Health em 27 ther tra		Roger W. Butt/son		Box 138	Fairfie	eld, PA		
0		20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from		natory`or other place) [0c. Location - City or	
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Depart Depart any i	ouce	a Mouse . Lav		. Name and Address		tzler Fu	neral Home	9 708
		23a. Part 1. Enter the disease, or complications that of shock, or heart failure. List only one cause on ea	aused the death. Do not ente					Approximate Interval Between
Physician	u ii	Immediate Course/Final	no Scienosis	Coner	my Ano	Terry D) ISEMSE	Onset and Death
	Medical resulting in death) Due to (or as a consequence of):							
LAGIIIIK		Sequentially list conditions, b.	mentla					
ed	E	f if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	or as a consequence of.					
execution and ial-train	Ž	that initiated events resulting in death) Last C. Due to (or as a consequence of):					
ate be executed ohysician and the burial-transit	dical Examiner	d						
ertifical iding ph								
death ce	Physician/Ma	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy Other (specify)	,		23d. Date of de Month	elivery Day Year
he de	hveiv	1 Yes 2 No 4 Freg 9 Unknown 9 Unkr		- Cittor (opcorry)				
that the ned by deta	у Р	Part II. Other significant conditions contributing to de	eath but not resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
quires quires en sig	Pad					1 🗆 Yes	2 No 3 P	Probably 4 Unknown
The law requires ate has been signated page 2 should be	Completed					24a. Was an autopsy	prior to	topsy findings available completion of cause of
The cate h	5					perform 1 Yes 2	ed? death? Xno 1 ☐ Ye	s 2 No
VILCII ysician: is certific director,	B	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:		Other	ce of Death (Check			
Physer this eral di	ļ.	27. Manner of Death 28a. Date		28c. Injury	at 2	ne 5 Ll Residen 8d. Describe how	ce 6 Other (Spec injury occurred	cify)
JUSTION OF all or Attending PI is after death. Il Director: After the ic in by the funera	15	2 Accident Investigation	h, Day, Year) injury	M 1 □ Y	∕es 2 □ No			
r Atter de lirecto	Certificate:		of Injury - At home, farm, streng, etc. (Specify)	eet, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ıral Route Number,
pital o				and the sine		d alore &= Alore =		1
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the base only one) 3 Certifying Nurse Practioner:	is of examination and/or invest	igation, in my opinion	, death occurred at	the time, date and	place, and due to the	cause(s) and manner stated.
To th withir To th	2	29b. Signature and title of certifier	391	29c. License	number	29	d. Date signed (Mont	h, Day, Year)
		I Sur Tun		D 4	17951	1	1-17-6	2010
A	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIBTE A-KAZMI, MD 814 TOIL HOUSE AUF- FREDERICK. MD 2170							
	tate	SIBTE A-KAZMI, MD 31. Date filed (Month, Day, Year) 32. R	814 Toll	110086	1	· ICNETIC		2.10
ى Regis		NOV 2 2 2010 Jenson >	B. park					

10-08518	
Cheryl Lee Bowers	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene 2010 35545

		1- For State Registrar		Certi	ficate of	Death			Reg. No.		
Physici		Decedent's Name (First, Middle						Date of D Month	Day Yes	3. Time of Death	
Medical Exam	iner.	Cheryl Lee E				City Town and	Leastion of D		er 7, 2010	0105 hrs	
		 Facility Name (if not institution 20507 Summersung L 			4	4b. City, Town, or Location of Death Germantown			4c. County of Death Montgomery		
Funeral		5. Social Security Number un	(6. Sex 7. Age	(In yrs. last	birthday)	If Under 1 Year		4.4:		9. Birthplace (State or Foreign Country)	
Director			1 M 2 X F	4	49 Yrs.	Months Days	Hours	Min. Nov 1	3, 1960	Pennsylvania	
		Usual Residence of Decedent								10d. Inside City Limits	
w any		10a. State 10b. County		-	own or Location					1 Yes 2X No	
Maryland 28a-f show d at once,	tor	MD Montg	omery	Ge	ermanto	10f. Zip Code			10g. Citizen of W		
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho maric event, the Medisal Examiner must be notified at once.	Director	20507 Summer S	ong Lane			Tot. Zip Code	2087	4	US.		
with th s 23a e noti	_	11. Marital Status	12. Was Decedent I	Ever in U.S.	13. Was	Decedent of His	panic Origin?	(Specify Yes or I	No- 14, Race	- American Indian, Black,	
leath v	Funera	1 X Never Married 2 Ma	Armed Forces?	X No		s, specify Cuban,				e, etc.	
after c	by F	3 Widowed 4 Dive	orced If Yes, Give Year or Dates:		1	Yes 2 X No	specify:		Specify:	white	
natur		15. Decedent's Education (Spec				s Usual Occupati st of working life.			16b. Kind of Bu	usiness/Industry	
5-0036 led within 72 hours afte Hygiene. I other than "natural", the Medical Examiner	ompleted	Elementary/Secondary (0-12)	College (1-4 or 5	+)			1			1	
with giene ther t	mo:	12 17. Father's Name (First, Middle,	2 Last)	l_	vete	rnairia:			anir e, Maiden Sumame		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be C	Herbert Bow	,					rbara Gr			
21; ould b d Men s mar	၉	19a. Informant's Name/Relationsh			19b. Mailing	Address (Street				n, State, Zip Code)	
MD d 2 sho lith and n 27 is		Melanie Botel	lo/sister						mantown,		
or Heal		20a. Method of Disposition 1 Burial 2 Cremation	3 Removal from Sta		ce of Disposit matory or othe	ion (Name of cen er place)	netery,	Date	20c, Location	- City or Town, State	
imore Pages 1 ment of H tant: If it		4 Donation 5 X Other Sp	ecify: in state								
Baltimore, permit. Pages I an Department of Hee Important: If ite		21. Signature of Euneral Service								ore Street	
		23a. Part I. Enter the disease, or	complications that caused t	he death. De	Ba1	timore.	MD 2.	1201 jac or respiratory a	arrest, shock, or he	art Approximate Interval	
Physician /Medical		failure. List only one cause	on each line. a. metaxalone							Between Onset and Death	
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	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse-	quence of):							
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9 E E	/Medical	X UNPENDED	AMENDED 27,	28a-f,	per ME	g909 1	1/30/1	O TT			
		IF FEMALE: 23b. Was decedent pregnant in th	e 23c. If yes, outcom	e of pregnar		Il death 3	Ectopic pre	egnancy	23d. Date of Month	delivery Day Year	
OX 68' ath certifi attending or use as	icia	past 12 months?	4 Pregnant at t	ime of death		er (Specify)				,	
Box re death c the atten red for us	Physician	1 Yes 2 No 9 V Unk	o onknown								
P.O.	by P	Part II. Other significant conditi	ons contributing to death	but not resu	itting in the un	derlying cause gi	iven in Part I.			ibute to the cause of death? Probably 4 Unknown	
ds, Fequires								24a. Wa		Were autopsy findings available	
of Vital Records, ng Physician: The law require After this certificate has been si nneral director, page 2 should b	Completed							aut	opsy	orior to completion of cause of death?	
tal Recian: The certificate Ector, page	녌							1 ✔ Yes		Yes 2 No	
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Phys Phys er this	은	1 Yes 2 No 27. Manner of Death	1 Inpatier		NOutpatient Bb. Time of Inj	0 001	v at Work?		e how injury occurr		
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Division tal or Attendir rs after death al Director: A	ertificati	a [77]	tigation 28e. Place of Inju				uilding, etc.	28f. Location	(Street and Numb	er or Rural Route Number, City Summersong Ln	
Divi	ertii		mined (Specify) for	und at	resid	lence		German	State)20507 town, MD	Summersong Ln	
	alc	29a. Certifier 1 Certifying Ph	ysician: To the best of my								
To the Hos within 24 h To the Fur completely	Medical		niner: On the basis of exam and manner stated	ination and/	or investigation			red at the time, da			
	Σ	29b. Signature and title of certifie	//(29c. License				ed (Month, Day, Year)	
		- 1/				O.C.N	VI. ∟ .		November	7, 2010	
OCME		30. Name and address of person Mary G. Ripple MD.	who completed cause of de Deputy Chief Medic			Penn Street,	Baltimore	MD 21201			
	tate						201011010	., 2 1201			
Regis	trar	31. Date filed (Month, Day, Year).	10 Sagustrar	p. 4	park			_			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month NOUSUSSL 172010 **Physician** 5:50 7 M JOSEPH BONIFACE √. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Randallstown Baltimore Chapel Hill Nursing Center 8. Date of Birth (Month, Day, Aug 26 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 6. Sex **Funeral** Months Days Hours Min. 1 M 2 □ F 86 1924 220-14-7902 MD Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 X No Director MD Randallstown Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21133 USA 3705 Hamor Court Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married If ***e**s, Give Year or Dates: 1 ☐ Yes 2 🔽 No Specify. white 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any Injury or other traumatic event, tra Magnetic agnes. Elementary/Secondary (0-12) College (1-4or 5+) civil engineer construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Agnes Dobry Nicholas Boniface ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3705 Hamor Ct., Randallstown, MD 21133 Ann Carolyn Boniface (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 D\Burial 2 □ Cremation 3 □ Removal from State Old Holy Family Cem. 11-22-10 Randallstown, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee P.O. Box 195 Sykesville, MD

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, P.O. Box 195 Sykesville, MD 21784 shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PROSTATE CANCER METASTATIC **Physician** /Medical Due to (or as a consequence of): Sequentially list conditions, if any leading to his additionates. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 5 ☐ Other (specify) 1 ☐Yes 2 ☐No 9 I Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 🗹 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural

Examiner Hospital or Attending Physician: The law requires that the death certificate be execute sician and burial-trans Division of Vital Records, P.O. Box 68760, 🧭 attending physician for use as the buria signed by the a After this certificate has been s funeral director, page 2 should it 24 hours after death. Funeral Director: A filled in by

with the Maryland

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

ed other than "natural", or items 23a or 28a-f show event, the Madical Evaminer must be notified at

Certification: To 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2

29d. Date signed (Month, Day, Year)

BOUTINONE MANYAND

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State Registrar

DIAMOND 2835 Smith RUENUE #203 31. Date filed (Month, Day,

29b. Signature and title of certifier

32. Registrar's Signature

CHIP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

R088852

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36547 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Day Year PM Daniel Rober November 3010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 XM 2 □ F Days 215-74-4294 48 Dec. 29, 1961 Baltimore, Maryland Usual Residence of Decedent 10a State 10b Counts 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2X No Maryland Baltimore County Manktan 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 15045 Jarrettsville Pike 21111 United States Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No 11, Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Year or Dates Specify White 3 Widowed 4 Divorced Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Auto Mechanic N/A Auto Repairs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Luther Barrett,Sr. Sadie Jane Price 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheri Lee Rider Barrett (Wife) 15045 Jamettsville Pike Monkton, Maryland 21111 20b. Place of Disposition (Name of cemeter, crematory of other place) Evans Funeral Chapel and Cremation Services, Inc. 20a Method of Disposition Date 20c. Location - City or Town, State (Harford Co.) 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State Monday 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland Nov. 22, 2010 21. Signature of Funeral Service Licensee Jeffrey L. Gair, Sr. 22. Name and Address of Facility reacceful Alternatives Funeral & Cremation Center, P.A. Lic.#M00677 2325 York Road Timonium, Maryland 21093-2215 23a. Art it. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Preumo cystis disease or condition resulting in death) PARLAMONIA Due to (or as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of)

Physician /Medical Examiner

permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evance.

Physician

/Medical

Examiner

Funeral

Director

or items 23a or 28a-f show

the Medical Examiner must be notified at

Director

Funeral

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Completed

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Physician/Medical

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Certification:

Medical

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Division of Vital Records, P.O. Box 68760 signed by has this ours after death.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of do 9 Unknown	I death 3 🗌 Ectopic			23d. Date of delivery Month Day Year				
Part II. Other significant conditions of	ontributing to death but not res	ulting in the underlyin	g cause given in Part I.		use contribute to the cause of death?				
				24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No				
25. Was case referred to medical examiner?	26. Place of Death (Check only one)								
1 ☐ Yes 2 ► No	Hospital: 1 🕽 Inpatient 2 🗌	6 ☐ Other (Specify)							
27. Manner of Death 1 Natural 2 Accident 3 Suicide 6 Could not by		28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju					
4 Homicide determined	28e. Place of injury - At ho building, etc. (Specify ysician: To the best of my know)	City or Town, State						

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number RES-000

State Registrar

Srivatsan 31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

30. Name and address of person

Raghavan 32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

November 17

DHMH 17 Rev 1/2001

within 24 hours a

To the Funeral C

completely filled

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 36548 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death illiam 3. Time of Death Blumenfeld Month Novembe 0105 0955 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ARDEN COURTS ASSISTED LIVING BALTIMORE BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Hours Min Months 213-16-6145 88 1^M7^h7^h1⁹21 Yrs MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits MD BALTIMORE OWINGS MILLS 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 REGALIA COURT, APT. #C 21117 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔽 No Specify. 3 X Widowed 4 Divorced Specify. WHITE Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 MACHINIST - QUALITY CONTROL MACHINE SHOP 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) NATHAN BLUMENFELD **EVA** SILVERMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DEBBIE CAPLAN-STADD/DAUGHTER 6350 RED CEDAR PLACE, #311, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/19/2010 BALTIMORE, MD Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between

Physician. Medical Examiner

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> should be

page 2

completed filled in by the funeral director,

Medical

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who con

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Physician/

Medical

Director

Funeral

Completed by

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Director

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"natural",

1 and 2 should be filed within 72 hours of Health and Mental Hygiene. I item 27 is marked other than "natur other traumatic event, the Medical.

permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic.

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examine sician and burial-transit Certificate: To Be Completed by Physician/Medical

To the Hospital or Attending Physician: The law requires that the death certificate be eximin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia

Division of Vital Records, P.O. Box 68760

disease or condition resulting in death)	Senile demer	A cor					
resulting in death)	Due to (or as a consequence of):		t				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury	leading to immediate Due to (or as a consequence of); Enter Underlying						
that initiated events resulting in death) Last	Due to (or as a consequence of):						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		Date of delivery Month Day Year				
Part II. Other significant conditions conti	ributing to death but not resulting in the underlying cause given in Part I.		ntribute to the cause of death? 3 □ Probably 4 □ Unknown				
		24a. Was an autopsy performed?	were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No				
25. Was case referred to medical examiner?	26. Place of Death (Check	only one)					
1 ☐ Yes 2 🔁 No		me 5 Residence 6 🕏 Ot	ther (Specify) ALF				
27. Manner of Death 1 Avatural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? M 1 ☐ Yes 2 ☐ No	8d. Describe how injury occu	rred				
4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Num City or Town, State)	ber or Rural Route Number,				
(Check 2 □ Medical Examiner	an: To the best of my knowledge, death occured at the time, date and place, and on the basis of examination and/or investigation, in my opinion, death occurred at Practioner: To the best of my knowledge, death occurred at the time, date and place	the time, date and place, and d	lue to the cause(s) and manner stated				

037573

29d. Date signed (Month, Day, Year)

Novemb

Battin

12, 5010

5/2001

Registrar DHMH 17 Rev 7/2009

State

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ase of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-07499 State of Maryland / Department of Health and Mental Hygiene Joseph Albert Clabaugh, Jr. 2010 36549 Certificate of Death Reg. No Registrar Decedent's Name (First, Middle Last) 2 Date of Death Time of Death Physician/ Month Day Year September 29, 2010 1610 hrs JR Clabaugh, **Medical Examiner** Joseph Albert 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Montgomery **Bethesda** NB I- 270 /Route 495 82**7/20/11/94/4**DD/YYYY 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Country) PA Months Days Hours 10/20/1944 168-34-1959 Director 66 1 X M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location iny 10a State 10b County 1 X Yes 2 No York Hanover PΔ or 28a-f show . Pages 1 and 2 should be filed within 72 hours after death with the Maryland iment of Health and Mental Hygiene. reant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other trammatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f Zip Code 10e. Street and Number USA 443 Baltimore Street 17331 14. Race - American Indian, Black, Funera Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces 1 Never Married 2 X Married 1X Yes White 1 Yes 2 X No specify: Specify: 4 Divorced If Yes, Give Year 3 Widowed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Police Officer Municipal 1 **Baltimore, MD 21215-0036** 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sma11 Marie Joseph Α. Clabaugh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 443 Baltimore Street, Hanover, PA 17331 Joyce Clabaugh, Wife 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 10/04/2010 Hanover, PA MT Olivet Cemetery Donation 5 Other Specify: & Crematory 17331 22. Name and Address of Facility Wetzel Funeral Home Inc., 549 Carlisle St., Hanover, PA 21. Signature of Funeral Service Licensee Stephen K. Miller, per DVR 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) Examiner if any, leading to immediate ceuse Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and cian/Medical Xamended#8perFH,G909,11/22/2010,WS UNPENDED attending physician or use as the burial Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Year Fetal death past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown certificate has been signed by the att ector, page 2 should be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a, Was an autopsy prior to completion of cause of death? performed' ✓ Yes 2 No 2 No 1 Yes 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Be examiner? Other Nursing Home 5 Residence 6 🗸 Other Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA this 1 🗸 Yes 2 No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? After 28b. Time of Injury 27. Manner of Death 1 V Natural 1 Yes 2 No Pending d in by the Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City n 24 hours after d e Funeral Direct 3 Suicide 6 Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cai (Check only one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. September 30, 2010 LZ E 30. Name and address of person who completed cause of death (Item 23a) 15 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Zabiullah Ali, M.D. 31. Date filed (Month V Registrar's Signatu

DHMH 17 Rev 1/2001 **OCME 2006**

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener) For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER Day 9 Alfred Collins 11:30 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Cheverly Prince George's 8. Date of Birth (Month, Day, Yea Mar 23, 1 Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral Hours 1 M 2 🗆 F Country) Florida Director Vrs 71 Mar 58-46-0262 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No DC Washington 10e. Street and Number 10g. Citizen of What Country? Funeral 5000 Nannie Helen Burroughs Avenue 20019 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 X Never Married 2 Married Completed by 1 ☐ Yes 2 ☐XNo If Yes, Give 1 ☐ Yes 2 🛣 No Specify: black 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) disabled none Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1200 G Street NW Suite 800 Washington, DC 20005 Rachel Long/attorney 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 🕅 Other (Specify) in state 21. Signature of Fineral Service Licensee Ronal of Wade, 3 Carend Andrewoning Board 655 W. Baltimore Street Director 21201 Baltimore, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate nterval Between HYPERTENSIVE Immediate Cause (Final Onset and Death Physician/ CARDIOVASCULAR Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Exami the Hospital or Attending Physician. The law requires that the death certificate be executed burial-transit Due to (or as a consequence of). resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Year Day Pregnant at time of death 2 No signed by the a d be detached f 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page performed 1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 📈 No Other: 1 🗌 Yes မြ 1 Inpatient 2 X ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pendina work? 1 ☐ Yes 2 ☐ No. n 24 hours after death.

e Funeral Director: After solution of the function of Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier 🖣 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Registrar DHMH 17 Rev 7/2009

State

within 2 To the I

29b. Signature and title of certif

31. Date filed (Month, Day, Year)

MARGARET

30. Name and address of person who completed cause of death Item 23a) (Type, Print)

Baltimore, Maryland 21215-0036

Box 68760

Records, P.O.

Division of Vital

3001

32. Registrar's Signature

HOSPITAL

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

31528

10-08349 Gerard Edwin Chodzinski Please

e Type or Print in Black Indelible Ink. Ensure All Copies Are Legib	le.	0.00
e Type or Print in Black Indelible Ink. Ensure All Copies Are Legib State of Maryland / Department of Health and Mental Hygiene	2010	3655
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ledical Exam	iner	Gerard Edwin	d Edwin Chodzinski Month Day Year November 1, 2010						1108 hrs		
		4a. Facility Name (if not instituti				b. City, Town, or	Location of Dea			4c. County o	of Death
		529 South Luzerne A				Baltimore					, 5000
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Funeral		5. Social Security Number unl	b. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year Months Day		fin. 8. Da	te of Birth (N	/IM/DD/YYYY)	Birthplace (State or Foreign Country)
Director			1X M 2 F	5:	9 Yrs.	Wioridis Day	/s Hours W	Ap	r 12,	1951	,,,
_		Usual Residence of Decedent	-								
any		10a. State 10b. County		10c. City,	Town or Location	on					10d. Inside City Limits
p # #	_	MD			Baltimo:	-					1 Yes 2 No
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/Medical		failure. List only one cause	on each line.						,,		Between Onset and
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		or condition resulting in death)	Due to (or as a	consequence of	"):						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 5:47 Mary Ann Deal 2010 November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville Shady Grove Hospital 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) (Month, Day, **Funeral** 1 M 2 X F 218-66-8964 54 Washington, DC June 1956 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County the Maryland Director 1 Yes 2 X No Maryland Frederick Mount Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21771 13002 Purdum Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black White etc. ☐ Yes 2 🔀 No ð 1 Never Married 2 Married 5-0036 72 hours after 1 ☐ Yes 2 X No Specify. Specify: White If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. within 7 Elementary/Seconday (0-12) 12 College (1-4 or 5+) Government Contract Specialist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental Fis marked or permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once. ပ Shirly Ann Athey Theodore Cumberland Maryl 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13611 Old Chapel Road, Bowie, MD 20715 Jeffrey W. Deal / Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 11/22/2010 Metropolitan Crematory Alexandria, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 RAY Rogers 23a. Part 1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death pneumonia Physician/ disease or condition Medical resulting in death) Die to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by acute renal failure 2 🕱 No 3 ☐ Probably 4 ☐ Unknown human immunodeticiency virus 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? performed? immune deticiency 1 ☐ Yes 2 ☐ No acquired After this certificate Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, Certificate: To Be examiner?
1 Yes 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Nation 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred iniury 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier NOVEMBER, 19, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Center Drive Rockville, mary land Medical 9901 Rane, Santosh 31. Date filed (Month, Day, Year) 32. Registrar's gnatur State Registrar

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			1 - State of Maryland State of Maryland		rtment of H		id Mental Hy	/giene Reg. No.	010	36553
	Physici: Medi		1. Decedent's Name (First, Middle, Last) Frank Drane				2. Date of De Month	eath Day	20 1 0	3. Time of Death
	Exami		4a. Facility Name (if not institution, give street and number) Seasons Hospice		4b. City, Town, or Rand	Location of D	eath	4c. Cour	nty of Death	
	Funeral Director		5. Social Security Number 431–62–4851 6. Sex 1 △ M 2 □ F 7. Age (In yrs. last 1	<i>birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hours N		rth 5, ^y 1936		hplace (State or Foreign Limont, AR.
	aryland a-f show ified at	ector	Usual Residence of Decedent 10a. State 10b. County 10c. City, To Maryland Baltimore Co. Bal	own or Loc						10d. Inside City Limits 1 ☐ Yes 2 🏲 No
	with the M 23a or 28 Ist be not	Funeral Director	10e. Street and Number 6307 Carlynn Ave.	CIMOI	10f. Zip Code	 1207		10g. Citizen o	of What Cou	untry?
036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. 7 Health and Mental Hygiene. 7 Health and Mental Hygiene. 9 Health and Sa or 28a-f show other traumatic event, the Medical Examiner must be notified at		11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates,			spanic Origin? n, Mexican, Pi	(Specify Yes or No- uerto Rican, etc.)	14. R	ace - Ameri ack, White,	ican Indian,
Maryland 21215-0036	vithin 72 hour jiene. er than "natur the Medical	Completed by		(Give ki	ent's Usual Occupa ind of work done do NOT use retired) unk.	tion uring most of	working	16b. Kind of	Business Ir	,
yland	Id be filed v Mental Hyg arked othe	To Be	17. Father's Name (First, Middle, Last) William Drane				Name (First, Middle, 7 Mae Smoo			•
	ind 2 shou lealth and m 27 is m her traum		Richard K. Abraham (Guardian)	504	Baltimore		Rural Route Number	er, City or Town, Marylar		Code) 1204
Baltimore,	Page nent c ant: If iry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Example 4 ☐ Donation 5 ☐ Other (Specify)	Funera ation S	ition (Name of atery or other place Dervices In		riday, v. 19,2010		Hill	, Maryland
Bal	permit. Departr Importa any inju	k /	21. Signature of Funeral Service Licensee Jeffrey L. Gair, Sr July J. Au. Lic. #M00677		Name and Address aceful Alto 2325 York I	of Facility Practive Coad	s Funeral & Timonium,Ma	Crematic ryland	n Cent 21093-	er P.A. -2215
	Enysician/		23a. Par 1. Enter the disease, or complications that caused the death. District, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition End-Stane Renal D	o not enter		, such as card	diac or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Medical Examiner	er	resulting in death) a. Due to for as a consequence of): Sequentially list conditions, b.							
108-	ate be executed ohysician and the burial-transit	dical Examiner	ff any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence)							
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Division of Vital Records, P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as t		F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal deadle Pregnant at time of death	ath 3 🗌	Ectopic pregnancy Other (s <i>pecify</i>)				ate of deliv	very Day Year
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sion of	Attending F r death. ctor: After t y the funera	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	o. Time of injury			28d. Describe h	ow injury occur	red	I Route Number,
Divi	spital or vous after neral Dire		building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge	e. death oc	cured at the time. o	late and place	City or Tow	rn, State)	ner as stato	nd .
	To the Ho within 24 ł To the Fu completec	Medical	(Check 2 Medical Examiner: On the basis of examination and only one) 3 Certifying Nurse Practioner: To the best of my known specific processing title of certifier	d/or investia	ation, in my opinion.	death occurre ime, date and	ed at the time, date a place, and due to the	nd place, and di	ue to the car nanner as st	use(s) and manner stated.
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N.S. Leya pake MD 2535 Sm. Th Ad 3733 Baltimer						65	11/	17	110	
	Stat		1. Date filed (Month, Day, Year) 32. Registrar's Bignatury	1		3 B	altimor,	, M.D. 2	.1201	7 .
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Nov. 15, 2010 Physician/ 6:10P Annie M. Dwight Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c, County of Death Keswick Nursing Home Baltimore Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Apr. 6, 1934 Director 239-54-0628 76 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If fem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must have accepted. 10a. State 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 431 Notre Dame Lane Apt.209 21212 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Specify: Black 3 🗌 Widowed 4 🖵 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Assistant Overlea Gardens Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Willie McMillan Macie Thompson 19a. Informant's Name/Relationship (Type, Print) (daughter) Aailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evon Dwight Matthews 1241 Deanwood Rd. Balto, Md. 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Donation 5 🗌 Other (Specify) Loudon Park Cem. Nov.23,2010 Balto,Md 22. Name and Address of Facility Calvin B. Scruggs Funeral Home ature of Funeral Service Licensee 1412 Preston ᠇ St. Balto, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final UMOR Onset and Death Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to in collect cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a conse vience of the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 ☐ Pregnant : 9 ☐ Unknown Pregnant at time of death 5 Other (specify) 9 Unknown is been signed by the should be detache Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵| 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has b page 2 sl autopsy performed? After this certificate 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) funeral director, Be Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation Director: ה 24 hous. the Funeral Directory filled in by th 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 within 2 To the I only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person

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who completed cause of death (Item 23a) (Type, Print)

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ieulcai Exami	ner	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of						of Death	Novemb		c. County o	f Death	1000 1113		
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Baltimore, permit. Pages 1 an Department of Hea Important: If itei injury or other tr		21. Signature of Funeral Service	acensee /			22 N	me and Ad	Alte	f Facility	ves F	uneral	and	Cremati	ian C	enter, P.A.
	\dashv	23a. Part /. Enter the disease, or o	complications that caus	ed the de	ath. Do no	ot enter the	mode of d				espiratory a				21093 Approximate Interval
Physician /Medical		failure. List only one cause of						,			,	,	,		Between Onset and Death
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154		30. Name and address of person v Zabiullah Ali, M.D. A	who completed cause of assistant Medical			11 Penn	Street, I	Baltim	nore, M	ID 2120	01				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Yea 23.30 M **Physician** Ann 18 2010 Patricia November /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number Days Hours **Funeral** Months 215-36-7705 73 Nov. 5,1937 MD Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b. County Baltimore 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at MD 1 ☐ Yes 2X No Halethorpe Director 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number United States 21227 321 First Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 24 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status be filed within 72 hours after dutal Hygiene. d other than "natural", or item 1 Yes If Yes, Give White 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. ò 3X Widowed 4 □ Divorced Year or Dates 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Education Teacher n/a 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First. Middle, Last. rmit. Pages 1 and 2 should be fili partment of Health and Mental Hy portant: If item 27 is marked oth y Injury or other traumatic event Be Louise Ruffo Elmer Minnick ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) 321 First Avenue Halethorpe, Maryland 21227 David Gurski / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Glen Haven 1 Burial 2 Cremation 3 Removal from State Department o Important: If any Injury or once. Nov.23,2010 Glen Burnie, MD 4 Donation 5 Other (Specify) Memorial Park 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Funeral Service Lice 1328 Sulphur Spring Road Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final aastroint estinal **Physician** upper disease or condition resulting in death) /Medical ue to (or as a equence of):, Examiner mueloid acute if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ician and burial-trans Due to (or as a consequence of) physician Physician/Medical the use 23d. Date of delivery 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month in the past 12 months? Day Pregnant at time of death 5 Other (specify) detached f 2 - No 9' Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?/ Yes 2 No page 2 2 No 1 🗌 Yes Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner' Other: 4 \sum Nursing Home Hospital: 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) မ 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification:

or Attending Physician: The law requires that the death certificate be executed Box 68760, P.O. 1 Division of Vital Records, Director: A within 24 hours a

To the Funeral C

completely filled Hospital

Baltimore, Maryland 21215-0036

5 Pending investigation 1 Tes 2 🗌 No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 - Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only one) 29c. License number 29d. Date signed (Month, Day, Year) MD 69614 November 18,

death (Item 23a) (Type, Print)

AM

600 North Wolfe St, Baltimore, MD, 21287

State Registrar

Medical

31. Date filed (Month, Day, Year)

29a. Certifier

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 8 2010 Physician/ NOVEMBER 1:15 PM GLICKMAN RUTH Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE N/ALEVINDALE HEBREW HOME Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. Hours 0870771918 Director 92 NY 053-01-4985 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at **Funeral Director** 1 ¥ Yes 2 □ No N/A BALTIMORE MD 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? 2434 W. BELVEDERE AVENUE, #156B USA Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: Specify: 3 X Widowed 4 Divorced Completed WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 ALTERATION SPECIALIST GARMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 UNKNOWN **ABRAHAM** MARKS MAMIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If Item 27 is any injury or other trau 2804 BANEBERRY COURT, BALTIMORE, MD ELLEN GLICKMAN/DAUGHTER-IN-LAW 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1X Burial 2 ☐ Cremation 3 ☐ Removal from State CHEVRA AHAVAS CHESED 11/19/2010 RANDALLSTOWN, MD 4 Donation 5 Other (Specify) 21. Signature of uneral Service Ligensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ ATHISMOSCIENOTIC CARDIOVA SWEAR DISTASE disease or condition / Medical resulting in death) Examiner Sequentially list conditions Examine if any feating to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown has been si e 2 should b 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy certificate ha performed? death? 2 1 Yes B B 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 욘 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work? 5 Pending 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State within 24 hours a

To the Funeral C

completed filled 29a. Certifier Lecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Division of Vital Records,

State Registrar

DHMH 17 Rev 7/2009

(Check

only one 29b. Signat

15R1A

31. Date filed (Month,

m

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1. WALLACE

Mid

32. Regis rar's Sig

2434

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D31136

W. BOLVEDERE AV

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are, Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dav 0200-5 Carl 1:13 pm 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Raven DCL fim ore If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Min 217-26-3401 1 XM 2 🗆 F MD Director Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at **Funeral Director** MD Baltimore 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21212 USA 5220 York Road Apt4 A 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 🛣 No 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Marlboro Apts Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade Service Customer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Earl Jones Loretta Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto, MD 21207 1444 Kirkwood Road Glenn Washington-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔲 Burial 2 💢 Cremation 3 🗆 Removal from State 11-23-10 Greenmount Balto, MD 4 ☐ Donation 5 ☐ Other (Specify) March East F/H 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1101 E. Balto, MD 21202 North Avenue Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsel and Death Immediate Cause (Final Physician/ 20207 Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 use as 1 attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Month Day Pregnant at time of death ed by the a detached f 9 Unknown cate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phr within 24 hours after death.

To the Funeral Director: After th completed filled in by the funeral 27. Man fer of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 Yes 2 No Investigation Accident ☐ Suicide ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier 😾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, NOV 2

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Om M **Physician** anor 4c. County of Death /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) BALTIMORE Examiner MORE IRVINGTON TURF CARI Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number Min Days MD **Funeral** 217-38-9507 1 ☐ M 2 🔀 F 5-8-1939 Director 10d. Inside City Limits Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 1 √Yes 2 No 28a-f show the Medical Examiner must be notified at Baltimore Completed by Funeral Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 5 21223 1010 W. Baltimore Street items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black White, etc. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Specify: Black Never Married 2 ☐ Married 1 ☐ Yes 2 No filed within 72 hours after ò, 21215-0036 3 ☐ Widowed 4 ☐ Divorced 'natural", 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation unemployed (Give kind of work done during most of working oyed life. DO NOT use retired) unemployed 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7/2 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any Injury or other traumeth. College (1-4or 5+) Elementary/Secondary (0-12) 10th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland Be Esther Mae John Clinton Jones ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20774 19a. Informant's Name/Relationship (Type. Print) Upper Marlboro, 3104 Barcroft Drive Carlecia Carroll-Daughter 20c. Location - City or Town, State Baltimore. 20b. Place of Disposition (Name of cemetery crematory or other place) 20a. Method of Disposition 11-22-10 Balto, MD Greenmount East F/H March 22. Name and Address of Facility 21. Signature of Funeral Service License 21202 MD23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1101 E. North Avenue Balto, Approximate Interval Between Onset and Death ASPIRATION Immediate Cause (Final disease or condition Physician Due to (or as a consequence of): /Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be exec Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical as the 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death IF FFMALE use Day 23b. Was decedent pregnant 3 Ectopic pregnancy Month for in the past 12 months? 5 Other (specify) Yes 2 No detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed t should be deta 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown ð Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No BROUASCULAR ACCIDENT autoosy has performe 1 ☐Yes 2 No After this certificate 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 Yes 2 No 1 Inpatient ٩ 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death Medical Certification: 1 Natural 2 ☐ Accident 5 Pending 2 ∏No 1 □Yes investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) after death Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by the 6 ☐ Could not be determined 3 ☐ Suicide 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

24 hours a sompletely filled hours Hospital within 2

> State Registrar

HASAN 31. Date filed (Month, Day, Year) 2010 22

29b. Signature and title of certifier

MD

AWAR

(Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAM MOUDS

29c. License number

21227

29d. Date signed (Month, Day, Year)

AMEND TTEM#20b, perFH G909 11/30/2010 WS State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Movember 13 2010 Physician/ 9:51 AM Johnson Harrison Medical 4b. City, Town, or Location of Death
Randall Stown 4c. County of Deal...
Baltimore 4a. Facility Name (if not institution, give street and number) **Examiner** Northwest Hospita If Under 24 Hrs. 8. Date of Birth Hours Min. 01 26 35 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 😾 M 2 🗆 F 75 **Director** 246-50-5236 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10d. Inside City Limits 10a. State 10c. City, Town or Location Be Completed by Funeral Director 1 X Yes 2 No Baltimore MD NA 10e. Street and Number 10g. Citizen of What Country? 21215 U.S.A. 3712 Bartwood Road 12. Was Decedent Ever in U.S. Armed Forces? 1. XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 V No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Bethlehem Steel 12th grade <u>Steel Worker</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Anthony Johnson Lillie Kittrell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Brother East Sharpneck St. Phila PA. Harold Golback-In-Law 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Ukn 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/30/10 Garrison Forest Vet. 21. Signature of Funeral Service Lice see 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between atheroscleratic Cardiovascular Disease Physician/ disease or condition Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Dunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5401 Old Court Rd, Randallstown, MD 51133 Tonya Mason 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Harrison

MOShya

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year 45 AM Margaret Osborne Jones . Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FRANKLIN Squa re Hospital Rosedale Baltimore Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2XXF Min. Hours 09/22/1946 Virginia Director 218-42-4555 64 Usual Residence of Decedent 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified Marvland Baltimore Middle River 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 602 Tidewater Lane 21220 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 2 any nijury or other traumatic event, the Medical Examiner mussince. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married þ 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Associate Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Mills Lovelace Elizabeth Shannon Burnett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Calvin Earl Jones (Son) 7315 Chesapeake Road, Baltimore, Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 🕅 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gard: 11/27/2010 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Eacility
Bruzdzinski Funeral Home, P.A.
1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nediate Cause (Final Onset and Death Physician/ Resurctory F

Due to (or as a consequence of): failure disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last RSA bacteremia attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical NON Hodakin Lymphoma Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Leukemia 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 N death? 2 No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death. To the Funeral Director: After this 28a. Date of injury (Month, Day, 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No Investigation Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town. State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Yuling Zhang, MD Nov, 22, 2010 D70605 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar OR YuLing 2 31. Date filed (Month, Day, Year) 9000

FRANKLin Sayare DR Balto nd

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36562 Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Matham Physician/ 100 A Carolyn Jones Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 02 - 16 -7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min. 1 🗆 M 2 🛛 F Days Hours 58 Director 218-56-1186 Yrs Usual Residence of Decedent 28a-f shov 10a. State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD NA Baltimore 1X Yes 2 ☐ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2545 W. Fayette Street 21217 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. African 'natural", or þ 1X Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 1 Yes 2 X No Specify: Specify: American Completed 3 Divorced 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once." 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker <u>12th Grade</u> <u>4yrs</u> Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Alpheus Jones Martha Fitzgerald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mike Thomas-Son 4006 <u>Liberty Heights Avenue Baltimore.MD</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 11-19-10 Metro Crematory Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Wylie Funeral Home P.A. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 638 N. Gilmor Street Baltimore,MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Physician/Medical Examine if any, leading to immediate cause. Linter Underlying Cause (Disease or linjury Due to (or as a consequence of): that initiated events Due to (or as a consequence of): resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: delivery Day e to the cause of death? þ ☐ Probably 4 🗹 Unknown Be Completed autopsy findings available to completion of cause of

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

Director:

Certificate: To

Medical

29a. Certifier

(Check

only one) 29b. Signature and title

3b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn. 1	tal death 3 🗌 Ectopic			23d. Date of delivery Month Day Yea
art II. Other significant conditions of	ontributing to death but not re	sulting in the underlying	g cause given in Part I.		se contribute to the cause of dea
				24a. Was an autopsy performed?	24b. Were autopsy findings ava prior to completion of cau death? 1 Yes 2 No
5. Was case referred to medical examiner?		ck only one)			
1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	ER/Outpatient 3 🗆	DOA Other: 4 Nursing H	Iome 5 Residence 6	Other (Specify)
7. Manner of Death 1 M Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be		28b. Time of injury M	28c. Injury at work? 1 □ Yes 2 □ No	28d. Describe how injury	occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	e 28e. Place of Injury - At he building, etc. (Specif		ory, office	28f. Location (Street and City or Town, State)	Number or Rural Route Number

29d, Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

upleted filled in by

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydieneo

			1 - For State amend 7, Registrar	8 per AB gS	aryland 112 2	d / Depa /4/Ц 	tificate of C	ieaith and i Death	vientai Hy	giene2 Reg. No.	010	36563
	Physicia	an/	1. Decedent's Name (First, Middle				- (2. Date of De Month	ath Day	Year	3. Time of Death
	Medi		ZATEARAH	BLESSING	I -	JOHV	SON		NOVENIB		2010	2:10 PM
	Examir	ner	4a. Facility Name (if not institution	,	.		4b. City, Town, or			4c. Co	unty of Death	1
-	Francisco		UNIVERSITY OF MARYLAND MEDICAL CENTER BALTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birt 9/25/								O Riet	pplace (State or Foreign
	Funeral Director		infant Usual Residence of Decedent	1 □ M 2 💢 F	- (m y 10. na	Yrs.	Months 19	Hours Min.	NOV 13	^{y, Year)} 010	Ma Ma	aryland
	and show	ò	10a. State 10b. County 10c. City, Town or Location									10d. Inside City Limits
	Maryl 28a-f otifier	Funeral Director	MD			Ba1	timore					1 ¥ Yes 2 □ No
	a or 3		10e. Street and Number				10f. Zip Code			10g. Citizen	of What Cou	untry?
	h with	ler	3941 Frisby St	reet			2	1218			USA	
	deat r iten iner r	굔	11. Marital Status	12. Was Decedent 8 Armed Forces?		. 13. V	las Decedent of His Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		Race - Ameri Black, White,	
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ted by	1 X Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	If You Give	No	1	☐ Yes 2 🛣 No	Specify:				lack
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b	iled w I Hyg othe vent,	Be	17. Father's Name (First, Middle, I	'			unk	18. Mother's Nam	ne (First, Middle,	Maiden Surn	_	
ılan	should be filed within 72 h and Mental Hygiene. 7 is marked other than "raumatic event, the Med	은						Dore	een Johr	son		
an	should and N is ma		19a. Informant's Name/Relations	nip (Type, Print)		19b. Mailin	g Address (Street a	nd Number or Rur	al Route Numbe	r, City or Tow	n, State, Zip	Code)
	nd 2 sealth m 27		University of N	MD Medical C	tr	22	S. Greene	e Street	Baltimo	re, MI	D 212	01
Baltimore,	e ± ± 5		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ∰ Other (S	pecify) in state	ce	ace of Dispos emetery, crem	sition (Name of atory or other place))	Date	20c. Locati	ion - City or T	own, State
Balt	permit. Pag Departmer Important any injury once.		21. Signature Funeral S. ru	wade, Made	ector	St	Name and Addres ate Anato 1timore.	sof Facility Board	655 W.	Balti	lmore S	Street
			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that caused	the death	. Do not ente	the mode of dying	, such as cardiac	or respiratory an	est,		Approximate Interval Between
-	Physician/		Immediate Cause (Final disease or condition	_ NECRO		NG	ENTERS	O COLITA	5			Onset and Death
1	Medical Examiner		resulting in death)	Due to (or as a								
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	ed	Examiner	if any meding to immediate cause. Enter Underlying Cause (Disease or iinjury	Title to for sess	Conseque	ence out						
	ath certificate be executed attending physician and for use as the burial-transit	Еха	that initiated events resulting in death) Last	C. Due to (or as a	conseque	ence of):						
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3760	ificate ig phy as the	Med	IE EEMALE.									
x 68	n cert endir r use	an/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live Birth	of pregnan 2 Fetal		Ectopic pregnancy	,		23d.	. Date of deliv	very
Вох	death the ath	Physician/N	1 Yes 2 No	4 ☐ Pregnant a 9 ☐ Unknown	t time of de		Other (specify)				Month	Day Year
P.O.	that the deg ned by the g detached		Part II. Other significant condition	ns contributing to death b	ut not resu	Ilting in the ur	derlying cause give	en in Part I.	23e Did to	nhacco use c	contribute to f	the cause of death?
ds, F	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	ed by										obably 4 🗆 Unknown
Sor	aw rec as bee 2 sho	Completed							24a. Was autor			opsy findings available ompletion of cause of
Rec	The Israte his	Son								rmed?	death?	
ta	ician: The certificate ector, pag	Be	25. Was case referred to medical examiner?	Hereign				ce of Death (Chec	k only one)			
Š	Physic this c al dire	_T	1 Yes 2 X No 27. Manner of Death			R/Outpatient		4 ☐ Nursing Ho				y)
0 4	ding I h. After funer	ate	1 🔼 Natural 5 🗌 Pendin			28b. Time of injury	28c. Injury work? M 1 🗆 S		28d. Describe h	ow injury occ	ourred	
sio	Atten deat ctor: y the	Certificate:	2 Accident Investig	not be	rv - At hon	ne. farm. stre		res Z 🗆 NO	28f Location /S	treet and Nu	mber or Rura	al Route Number,
Division of Vital Records,	al or / s after il Dire		4 ∐ Homicide determ	building, etc		,,	ot, ractory, occ		City or Tow		The of The	Tioble Names,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	(Check 2 Medical E	Physician: To the best of xaminer: On the basis of ex	amination	and/or investi	gation, in my opinior	n, death occurred a	t the time, date a	nd place, and	due to the ca	ause(s) and manner stated.
	To the within to the comp	2	29b. Signature and title of certifier		_ 50. OI IIIIy	olouge, u	29c. License				gned (Month,	
			· Comen	ru m.D			1649	50216	, 2	11/1	3/2	010
			30. Name and address of person v	·			int)	_				
			CHINAZO ME 31. Date filed (Month, Day, Year)	NIRU 23	S.	HTUO	GREEN	STREET	BALT	IMORE	MI	21201
	Stat Registra		NOV 2 2	010 June 22. Registra	rs Signatu	ire par	las			<u> </u>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UTI U For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Medical 16 Yes Arnol 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner GILCHRIST HOSPICE CARE TOWSON BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) Funeral Months Days Min. 0CT . 31, Year) 1923 1 ★ M 2 □ F 217-16-3234 87 MD Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be accessed. 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 Yes 2x No MD **BALTIMORE BALTIMORE** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8810 WALTHER BLVD.. 21234 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14, Race - American Indian, 11. Marital Status Armed Forces?
1 X Yes 2 ☐
If Yes, Give Black, White, etc. 1 ☐ Never Married 2 🙀 Married 1 ☐ Yes 2 🙀 No Specify: WHITE Specify: 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ELECTRICAL DESIGNER GAS & ELECTRIC Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ **JACOB JACOBS** LENA RIFKIND 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LOUISE JACOBS/WIFE 8810 WALTHER BLVD., #1202 , BALTIMORE, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date MTRRO I SRAEL CEMET 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CEMETERY 11/19/2010 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 ature of Funeral Service Licens 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cancer -400 disease or condition) Medical resulting in death) Due to (or as consequence of) Examiner Sequentially list conditions, Examiner ri any, leaving to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of, been signed by the attending physician and should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 No 1 Yes 2 Unknown this certificate has been signed by the areal director, page 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 🗌 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? portret 1 Yes 2 No Hospital Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completed filled i 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier City, song Anne Lewis Villanners, CRDP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 4105 31. Date filed (Month, Day, Year)

NOV 2 2 2010 State NOV Registrar N DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	D!		1. Decedent's Name (First, Middle, Last)		_		2. Date of Deat	h	3. Time of Death		
	Physici /Medio		Thelma R.	Ke.	lly		Nov. 1	0, 2010 Year	7:10A ^M		
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Lo	ith					
			Long Green Center 5. Social Security Number 6. Sex 7. Age (In yrs. last.	hirthday)	Baltimos	re TUnder 24 Hrs.	N/A	rthplace (State or Foreign			
	Funeral Director		217-22-9882 1 M 2 F 90	Yrs.		Hours Min.	8. Date of Birth (Month, Day, 09 / 17 /	Year) C	ryland		
	pu ,		Usual Residence of Decedent				00/11/	1320 110			
	shov	ō	10a. State 10b. County 10c. City, To						10d. Inside City Limits 1 Yes 2 No		
	the M	Director	MD N/A E	Balt.	imore		Og Citizen of What C	Citizen of What Country?			
	3a or		115 E. Melrose Avenue		21212		U.S.A.				
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of Hispa Yes, specify Cuban, I	anic Origin? (S	pecify Yes or No-	14. Race - Am	14. Race - American Indian, Black, White, etc.		
36	or ite		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💆 No			spec <i>ity:</i>	o nicari, etc.)				
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15	within 72 hours after death with the Maryland lene. than "natural", or items 23a or 28a-f show I's Madical Examinar nast by neithed at	Completed	(Specify only highest grade completed)	(Give I	ent's Usual Occupatio kind of work done duri O NOT use retired)			16b. Kind of Business	Andustry		
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pu	be file tal Hy d othe	Be (17. Father's Name (First, Middle, Last)		18	3. Mother's Nam	ne (First, Middle, M	Maiden Surname)			
yla	ould I	٦	Rilou Kelly			Maggie		Smith			
Maryland 21215-0036	d 2 sh Ith and 17 is n traun				,			; City or Town, State, re, MD 2			
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Jan Jan	Examiner		Due to (or as a consequence CAVLING No.	e of):	IAP	11. 10. 1	1				
		je	Sequentially list conditions if any, leading to immediate b. Due to (or as a consequence	e of):	L-111-	4141	201				
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Вох	death atter	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No ☐ Pregnant at time of death		Ectopic pregnancy Other (specify)			23d. Date of de Month	Day Year		
<u>о</u> .	it the d by the tached	Physician/Me	9 ☐ Unknown 9 ☐ Unknown								
S, F	es ti gne ge c	by P	Part II. Other significant conditions contributing to death but not resulting	in the un	derlying cause given i	n Part I.	23e. Did tob	acco use contribute t	to the cause of death?		
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a	n: The ficate r, pag						perform 1 □ Yes 2		s 2 No		
<u> </u>	Physician: The Is rethis certificate har all director, page 2	Be C	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: The patient 2 FR/6	D	Lou	/	th (Check only one				
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<u>0</u>	tending Fileath. tor; After the funera	atio	1 ☑ Matural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident investigation	Injury	M 1 ☐ Yes	2 □ No					
Division of	or Atter de office de offi	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, stre	et, factory, office		28f. Location (St. City or Town	reet and Number or F n, State)	Bural Route Number,		
	pital c		29a. Certifier 1 V Certifying Physician: To the best of my knowled		1.10						
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certified completely filled in by the funeral director, p	edical	29a. Certifier (Check only one) 1	ge, death and/or inv	occurred at the time, estigation, in my opini	date and place ion, death occu	red at the time, d	ause(s) and manner a ate and place, and du	as stated. le to the cause(s)		
	To the within To the sompl	Me	29b. Signature and title of certifier		29c. License nu	umber	2	9d. Date signed (Mon	th, Day, Year)		
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			30. Name and address of person who completed cause of death (Item 23a) (Type, P	rint) A. / o	12-11	~	mhit	1217		
			31. Date filed (Month, Day, Year) 2. Registrar's Signature	11(21)	OSI AVI	, Will	insere,	1114	1616		
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DHMH 17 Rev 1/2001

TABAREH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Koehler 4:00 AM Darbara NOV 010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death University of Maryland Medical Center Bultinore N/A 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** 1 M 2 X F Days Hours Min. (Month, Day, Year) 11/20/1933 059 28 3224 Director 76 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Marvland N/A Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4125 Doris Avenue 21225 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify. Completed 3 X Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 4 years Sales Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gilbert W. Foster Bessie Ackerman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Fitzgerald 4125 Doris Avenue Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Bayview Crematory 11/12/2010 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signatur Fune al Service Lic 22. Name and Address of Facility Gonce Funeral Service. P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death cerebral is a consecu Physician/ disease or condition resulting in death) days Medical Due to (or as a consequence of) Examiner pertension Sequentially list conditions, if any editions cause. Enter Underlying Cause (Disease or iinjury Dula to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant
Unknown Month Dav Year 1 Yes 2 9 Unknown Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 No မ 1 Enpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending 1 Tyes 2 🗌 No Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours To the Funeral Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one Germying Nurse Practioner To the best of my knowledg 29b. Signature and title of certifie AU4176435B100552 Nov 11, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brown hristopher South Baltimore MD 2120 32. Registrar's Si State Registrar

DHMH 17 Rev 7/2009 COW 3252

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 12:34PM KAROPCHINSKY ATRICIA November 2010 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Baltimore Bayview Medical Center N/A Horkins 8. Date of Birth (Month, Day, Aug. 16 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Hours Months Days 1 □ M 2 🗓 F MD Aug. 1951 217-58-4518 59 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☐ No Baltimore Maryland Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21122 1303 Tar Cove Road 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 1 ∏Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married White 1 ☐ Yes 2 ☑ No Specify 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Household Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) E11a Tracev David Tull 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1303 Tar Cove Road, Pasadena, MD 21122 Harry E. Karopchinsky (spouse Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Nov 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2010 Crownsville, Maryland Maryland Veterans Ceni 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Fune Stallings Funeral Home, P.A 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Respiratory Days disease or condition resulting in death) Due to (or as a consequence d): Month Intra cerebra Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Glioblastona Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Vear Month 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 TYes 1 ☐ Yes 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

"natural", or Items 23a or 28a-f show clical Examiner must be notified at

7 is marked other than "natur traumatic event, the Medical

of Health

Item 2

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

/Medical

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Physician/Medical þ Completed

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Examiner the burial-trans Medical Certification: To Be

attending p been signed by the should be detached this certificate has but director, page 2 sl this funeral After within 24 hours after death

To the Funeral Director:
completely filled in by the f

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

State Registrar

resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown 25. Was case referred to medical examiner's 1 Yes 2 No 27. Manner of Death 1 Natural
2 ☐ Accident 5 | Pending investigation 6 ☐ Could not be 3 ☐ Suicide determined 4 Homicide

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year)

28b. Time of Injury 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28d. Describe how injury occurred

Baltimore

29c. License number

29d. Date signed (Month, Day, Year) 2010

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD. 4940 Eastern Avenue J. Merer David 32. Registrar's Signature 31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

and manner stated.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 03/10 NOV 5 201 dubuch /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner AGNES TOSPITAL Birthplace (State or Foreign Gountry) If I Inde 8. Date of Birth
(Month, Day, Year)
9-30-190 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Days Hours 1 → M 2 □ F 215-88-604 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene. snt: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State ral", or items 23a or 28a-f show 1 ⊈Yes 2 No Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number apr 2121 Funeral 0110 12. Was Decedent Ever in U.S.
Armed Forces?
1 Yes 2 DNo
If Yes, Give
Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: Black 3 Widowed 4 Divorced Completed er than "nature, 16b. Kind of Business/Industry Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ Weira 19b. Mailing Address (Street and Number or Flural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3600 item 2 20b. Place of Disposition (Name cemetery, crematory or other Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any Injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fuhern a Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final NEEK **Physician** 515 SET disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be execute attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown EDWARD Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 2 🗌 No 3 Probably 4 Unknown After this certificate has been funeral director, page 2 shoult 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 1 ☐ Yes 1 □Yes **Division of Vital** Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 (No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐Yes 2 ☐No death. investigation 2 Accident after death filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 3

Registrar DHMH 17 Rev 1/2001

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JONATHAN 31. Date filed (Month, Day,

State Registra

OCME 2006

111 Penn Street, Baltimore, MD 21201

Carol Allan, MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

2010

Assistant Medical Examiner

OCME

aci

Baltimore, Maryland 21215-0036 To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

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			Certificate of Death		eg. No.	
			1. Decedent's Name (First, Middle, Last)	2. Dete of Deat	th	3. Time of Death
	Physici		Robert S. Lamont	Month	Day Yea	
	/Medic Examir		4e Facility Name (If not institution, give street end number) 4b. City, Town, or Lo	cation of Death	4c. County of D	eath
	= 7.641111		University Of Maryland Baltin	nore		
	Funeral		5. Social Security Number 6. Sex 7. Agel (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Dey	(9.1 Year)	Birthplace (State or Foreign Country)
	Director		219-62-5997 APM 2DF 56 Yrs.	Apr 1,	1954 M	aryland
	pue »		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	sho	5	MD Baltimore			1√⊡ Yes 2 □ No
	the N	ect	10e. Street and Number 10f. Zip Code	1	0g. Citizen of What	Country?
	with with	Funeral Director	314 S. Poppleton Street 21230		USA	
	eath	era	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - A	merican Indian,
' 0	r Her	E	1 🕅 Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 No	Rican, etc.)	Black, W	/hite, etc.
98	urs a	ð	tf Yes, Give 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		Specify:	white
Q Q	be filed within 72 hours after death with the Marylend tal Hyglene. d other than *netural', or Herns 23a or 23a-f show event, the Modical Examiner must be notified at	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grede completed) (Give kind of work done during most of work	ina	16b. Kind of Busine	ess/Industry
7	thin 7	ple	(Specify only highest grede completed) [Give kind of work done during most of work life. DO NOT use retired) [Give kind of work done during most of work life. DO NOT use retired)	y		
7	od wi	Con	10 0 carpenter			cuction
pu	d oth	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, i	Maiden Sumame)	
<u>X</u>	should Ind Meni	ဥ		s Marie		
Maryland 21215-0036	2 sh and is m		19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (<i>Street and Number or Run</i>			
	1 and Health em 27 ther tr		Lisa M. Temple/sister 1230 Ten Oaks Road Ba		MD 2122 20c. Location - City	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylen Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 25a-f show any injury or other traumatic event, the Medical Examiner must be neitined at ance.		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	Date	200. Location Oily	or rown, otato
ij	then tant:		4 ☑ Donetion 5 ☐ Other (Specify)			
Bal	permit. Depertrimporta		21. Signature of Funeral Service Licensee Ronald S. Wade Director State Anatomy Boar		. Baltimor	re Street
	40144		Baltimore, MD 212			
			23a. Part. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arr	rest,	Approximate Interval Between Onset and Death
7	Physician					7
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)			SMOS
п		-	Due to (or as a consequence of):			
	ted nsit	edical Examiner	b			
	tificate be executed ng physician and es the burial-transit	Xal	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			
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68	flicate g phy ss the	B	resulting in death) Last			
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m	deeth e ette	Cla	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did to	obaçco use contrib	oute to the cause of death?
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ord	en si	8	HYTERTENJION	24a. Was a perfor		tb. Were autopsy findings available prior to
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Division of Vital Records, P.O. Box	lan: artifica ctor,	Be (25. Was case referred to medical examiner?	th (Check only or	ne)	
×	hysic nis ce il dire	ို	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Ho		ence 6 Other (5	Specify)
בַ	Attending Physician: or deeth. ector: After this certifici by the funerel director,	Ë	1 ☑Naturel 5 ☐ Pending (Month, Deý Year) Injury Work?	28d. Describe h	ow injury occurred	
sio	eeth. or: A	cati	2 Accident investigation 3 Suicide 6 Could not be	Opt Location (C	troot and Alumbar o	r Rural Route Number,
\leq	or At after d Direct in by	E	3 Suicide 4 Homicide Suicide Suicide	City or Tow		r riara rioute rumosi,
	pital bers filled	2	29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, death occurred et the time, date and place,	end due to the o	ause(s) and manne	r as steted.
	Fun Fun etely	edical Certification: To	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	red at the time, o	date and place, and	due to the cause(s)
	To the Hospital or Attending Physician: The lew requires that the deeth cer within 24 hours after deeth. To the Funeral Director: After this certificate has been signed by the ettendin completely filled in by the funeral director, page 2 should be detached for use	2	29b. Signature and title of certifier 29c. License number		29d. Date signed (M	fonth, Day, Year)
	- 5 - 0		N as ATTENDAL DIS	640	11/11	110
,			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		110	
			Pasnee mi)			
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
	Registr	ar	NOV 2 2 2010 Genera B. Larles			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MICHAEL ALLEN LESSER Month 1232PM Medical 2010 vembe 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital Baltimore Baltimore City of 5. Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12-25-1946 Birthpic Country) MD 9. Birthplace (State or Foreign 1 √2 M 2 □ F Months Hours Min. Director 216-44-1254 63 Usual Residence of Decedent 10a. State 10b. County death with the Maryland Director 10c. City. Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f s edical Examiner must be notified MD BALTIMORE BALTIMORE 1 🗌 Yes 2 🖵 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7211 VALLEY COUNTRY COURT A3 21208 USA 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🗓 No Specify: Completed 3 Divorced 4 Divorced Specify \mathtt{WHITE} Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than Michael Lesser life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) CLERK GIANT FOOD Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည HARRY LESSER ESTHER BRAWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $618\ COLORADO\ AVE;\ BALTIMORE,\ MD\ 21210$ permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau JACK LESSER / BROTHER 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place HEBREW YOUNG MEN 11-19-2010 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Sig License 8900 REISTERSTOWN RD; BALTIMORE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ardiac acrest day Medical Due to (or as a consequence of) Examiner Drobable Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 JE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Yes 2 No 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been siç , page 2 should b Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 2 No Yes 2 1 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ျ 2 | No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes Accident
Suicide Investigation 2 🗌 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Destroying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Destroying Physician to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number RES November 16, 2010 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kachel MD Hallmark Baltimore sinai Hospital 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien@ 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** Henry Frederick Meyers 2044 11 17 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Agnes 6. Sex Bultimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 5 Martin 19443 5. Social Security Number 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) **Funeral** 1 → M 2 □ F 212-42-5215 67 Yrs. **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the McCloal Evareiner must be notified at Director 1. Yes 2 No MD Baltimore City Baltimore City 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1711 Desoto Rd 21230 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No if Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: White ģ 3 ☐ Widowed 4 🖾 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Printer Bindery 7 is marked other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 nent of Health and Mental ပ Frederick Mevers Minnie Willingham 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any Injury or other trau once. Charles Meyers -nephew 1711 Desoto Road, Baltimore, MD 21230 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Buxial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery: 11/23/2010 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service cens 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd, Lansdowne, MD 21227 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Necrotic Small /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Unoritying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Ö After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 ☐ Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2 □ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To To the Hospital or Attending Privitin 24 hours after death.

To the Funeral Director: After the completely filled in by the funera 27. Manher of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 823628 2010 30. Name and appress of person who completed cause of death (Item 23a) (Type, Print) Stagrak Ave Baltimore 900 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 22 2010 Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 3 5 7 Legibles of Maryland 7 Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month MORMS WAYNE 753 AM Physician/ 2010 JOE Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner HO WAND HOSA MY COCUMBIA Homen COUNT If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8 Date of Birth 6. Sex 7. Age (In yrs. last birthday) **Funeral** Month, Day, Min 1 1 M 2 - F Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland Director 1 ₩ Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number items 23a or ner must be n Funeral 2104 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 Ves 2 No 11. Marital Status the Medical Examiner Black White etc. 0 þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: White If Yes, Give "natural", 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation 16h Kind of Business Industry 15. Decedent's Education Give kind of work done during most of working life. DO NOT use ratired) (Specify only highest grade completed) al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) th and Mental H 2 Morri ANN Page 1 and 2 should be intent of Health and Menta 19b. Mailing Address (Street and Number or Rural Route Numb City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other traconce. Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location 1 Burial 2 Cremation 3 Removal from State rownsville 4 Donation 5 Other (Specify) neral Service Lio 22. Name and Address of Facility 1022 Approximate Interval Between 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory Onset and Death Immediate Cause (Final INFARCTOR MYO CARDIAL Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if an eleading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Year Other (specify) Pregnant at time of death signed by the a d be detached for Unknown 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes Records, Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 Yes 2 No this certificate Yes 2 No **Division of Vital** To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, å examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ဂ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After t work? 1 ☐ Yes 2 ☐ No iniury 1. Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu after death. Investigation 2 Accident
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2010 050538 15 NO V. d address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

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State Registrar 5755 Cedar Lane

32. Registrar's Signatur

Ann Mihalick

31. Date filed (Month, Day, Year,

Columbia, MD 21044

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 36575 State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0115AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner omwel altimore 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 2 📈 F Days Hours Aug'l 1a, 1929 Vîrginia 220-22 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho 72 hours after death with the Maryland Director 1 🗌 Yes 2 😾 No York Hanover 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 17331 U.S.A. 59 Blenheim Street 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed Year or Dates er than "natur, the Medical E 16a Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Med once. Elementary/Seconday (0-12) 6 th College (1-4 or 5+) Own Home Home Maker Be 17. Father's Name (First, Middle, Last) (unk) 18. Mother's Name (First, Middle, Maiden Surname) 2 Margaret Overstreet Booth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Blenheim Street Hanover, PA. 17331 <u> Thomas Patrick Tosh (son)</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) November 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State Bayview Crematory 17, 2010Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility aczorowski Funeral Home, FA 21, Signature of Funeral Service Licenses 1201 Dundalk Avenue Baltimore, Md.21222 se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or y a consequence of): Examiner Sequentially list conditions, Examine if any, leading to himediate cause. Enter Underlying Cause (Disease or linjury that initiated events use as the burial-tran Due to (or as a consequence of) resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be ex Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No for Year Month Day 4 Pregnant at time of death 9 Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed?
☐ Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be funeral director, 26. Place of Death (Check only one) Hospital 2 No ျာ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Mursing Home 5 Residence 6 Other (Specify) 27. Manner of Deat 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at s after death.

I Director: After to in by the funera 28d. Describe how injury occurred Certificate: 1 Natural work? 1 \(\text{Yes} \quad 2 \(\text{D} \text{ No} \) injury 5 Pending Investigation Accident within 24 hours after dex To the Funeral Director completed filled in by th Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 💢 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 15888 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 8710 32. Registra State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MCLEOD CELIA Year 12:25 MM 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PINECREST 7205 Baltimore CATONSVILLE 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 1 🗆 M 2 🗷 F Country) SC 217.40.33 Hours Yrs Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hyglene. is marked other than "natural", or items 23a or 28a. tehm 10c, City, Town or Location Caton SVILLE ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County **Funeral Director** 10d. Inside City Limits MD Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? T205 Pinecrest USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑No Specify: Black Completed 3 ₩ Widowed 4 □ Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Musician Church 12th crade Hyears Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Martha James Washington Butler permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic onee. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) C. McLeod Velun Road Caton sville MD 21228 Pinecrest 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Nandard National 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Vaughn C. Greene Funeral Services 1 dallstown MD 21133 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph, sician/ DEMENTIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Day Year signed by the a d be detached t Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ page 2 should Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown CHF 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? ESRF 1 ☐ Yes 2 🔀 No Yes 2 No 25. Was case referred to medical the funeral director Be 26. Place of Death (Check only one) 1 ☐ Yes 2 XNo 2 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation Could not be within 24 hours after deat To the Funeral Director: Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) R171311 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SULTE G LIN THICUM D.L. COLEMAN, CRNP 705 DIGITAL MD21096 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 22 2010 Dark Registrar

Registrar

DHMH 17 Rev 1/2001
OCME 2006

State

ark

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

Pamela E. Southall, MD

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2010 5:30 PMM November - Janet Christine Miller-Shaw 4a. Facility Name (if not institution, give street and number) Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore 1801 Spence Street #B 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Dec 27, 1950 Days 1 🗆 M 2 🛛 F Months Hours Maryland 59 Yrs. Director 213-58-0302 Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at by Funeral Director 1 X Yes 2 ☐ No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21230 1801 Spence Street #B Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ▼ No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: white If Yes, Give Specify: Completed 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) 12direct sales home interior Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ is marked Christine Mae Keyser Garnet Leo Couch other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $916~{\rm Freeman~Street~Brooklyn,~MD}~21225$ and 19a. Informant's Name/Relationship (Type, Print) Courtney Shaw/daughter Health a tem 27 i 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) of Funeral Service License Ronald S Signatur 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, ΜĎ 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) arterioselentes Physician/ ardionas arlar Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): ysician a e burial Physician/Medical death certificate be 68760 attending p for use as t 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Box in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year signed by the a Id be detached f g 🗌 Unknown P.O. that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 ☐ Probably 4 ☐ Unknown Records, 1 Tes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 1 🗆 Yes 25. Was case referred to medical of Vital 26. Place of Death (Check only one) Be examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🗌 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending (Month, Day, Year) injury To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fun Division M 1 Yes 2 No Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) and title of certifier 29b. Signature 29c. License number cause of death (Item 23a) (Type, Print) 30. Name and address of person who 821 N. EUTAW ST STEZOZ BACTO MO21267 31. Date filed (Month, Day, Year)
NOV 2 2 2010 State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Degible. 36579
State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	ate of warylar		tificate of L			gierie Reg. No.	
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)	Examin	er	4a. Facility Name (if not institution, give street a	,		4b. City, Town, or		th	4c. County of [Death
E	uneral		2331 Mc Culloh St. 5. Social Security Number 6. Sex	7. Age (In yrs. Ia	ast hirthday)	If Under 1 Year	imore	8. Date of Birti		Pill I Cold 5
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and	show I at	ō	10a. State 10b. County	10c. Cit	y, Town or Loc	ation				10d. Inside City Limits
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the l	a or 2 be no	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	t Country?
th with	ns 23 must	ner	2331 McCulloh Str	eet		21	217		U.S.	Α.
nd 21215-0036 filed within 72 hours after death with the Maryland al Hygiene.	ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	Arm	s Decedent Ever in U.S ned Forces?] Yes 2 [X No	S. 13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (S In, Mexican, Puer	pecify Yes or No- to Rican, etc.)	Black, V	American Indian, Vhite, etc.
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/lan		욘	William Covington			ŧ	Ruth Mi		raiden ourname)	
Marylan should be file	or other traumatic		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street a	and Number or Ru	ıral Route Number,	City or Town, State,	, Zip Code)
	im 27 her tr		John Porter-Son 20a. Method of Disposition		123	hateau				, PA 17378
	or other		1 X Burial 2 ☐ Cremation 3 ☐ Remove	20b. Pl	lace of Dispos emetery, crem	ition (Name of atory or other place	e)	Date	20c. Location - City	or Town, State
Saltimore, bermit. Page 1 and Department of Hea	nrtant njury		4 Donation 5 Other (Specify)		_			/24/201	0 Woodla	awn, MD
baltimo permit. Page 1 Department of	any ir		21. Signature of Funeral Service Licenses	Keke	Ma 43	Name and Address 1°Cn F/F 300 Waba	i for West ash Ave	, Balti	more, M	d 21215
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that .		9 6	Part II. Other significant conditions contributing	g to death but not resu	Iting in the un	derlying cause give	en in Part I.	23e. Did tob	acco use contribute	to the cause of death?
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law re	e 2 sh	Completed						24a. Was an		autopsy findings available to completion of cause of
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sician		m	25. Was case referred to medical examiner?				ce of Death (Chec	ck only one)		
Phys	eral di	으 ;;	T Lifes 2 Pariso	1 ☐ Inpatient 2 ☐ E Date of injury 2	R/Outpatient 28b. Time of	3 DOA Other	4 ☐ Nursing H		nce 6 Other (Sp	ecify)
Attending Physician: The law requires that the death ce of coors of feath.	he funer	Certificate	1 → Natural 5 ☐ Pending 2 ☐ Accident	(Month, Day, Year)	injury	work?	at ∕es 2 □ No	28d. Describe how	v injury occurred	
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A	in by t	5 5		Place of Injury - At homouilding, etc. (Specify)	ne, farm, stree	t, factory, office		28f. Location (Str. City or Town,		Rural Route Number,
spital hours neral	pallil ed	<u> </u>	29a. Certifier 1 Certifying Physician: To	the best of my knowled	dge, death oc	cured at the time.	date and place a	nd due to the caus	e(s) and manner as	etated
he Ho in 24 he Fu	pletec	Med	(Check 2 Medical Examiner: On the only one) 3 Certifying Nurse Practic	e basis of examination a	and/or investig	ation in my opinion	death occurred	at the time data and	place and due to the	
7 등 전 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	CO T	2	9b. Signature and title of certifier	1		29c. License			d. Date signed (Mo	
	_		reel bo		_	1015	8/0	4	VOV 19	2010
	1	3	0. Name and address of erson who completed	cause of death (Item 2	(Type, Pri	100	18/	01	1 21	061
	State	3	1. Date filed (Month, Day, Year)	32. Regi ye rar's Signatur	4/5	4 17000	41714	Blu	10 4	
Re	gistrar		MAY 2 2 2010 Denent	1. A. a.	100					

Division or Vital Records, P.O. Box 68760 0

3altimore, Maryland 21215-0036

Certification: 5 Pending investigation 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

BABATUNDE 31. Date filed (Month, Day, Year) State

MD 2434 W. BELVEOGRE AVE. BATTIMORE MY) AJAN1 32. Registrar's Signature

ATTENDING

NOV 2 2 2010 parke

PMYSICIAN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEVINDATE CERTATRIC

D0064533

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** November 0942M 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** 8. Date of Birth Jan22, 1928 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** 1 □ M 2 XF Days Hours Min 82 Pennsylvania 220-24-7228 **Director** Usual Residence of Decedent the Maryland ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ¥ Yes 2 □ No Director Md. Baltimore City 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? filed within 72 hours after death, with 2903 Fait Avenue 21224 U.S.A. items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian, ntal Hygiene. ed other than "natural", or iter event, the Medical Examiner Black White etc. 1 Never Married 2 Married 1 ☐ Yes 23 If Yes, Give Year or Dates 2X No 21215-0036 1 ☐ Yes 2X No Specify <u></u> 3 ₩ Widowed 4 □ Divorced Specify: White Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Public Works Elementary/Secondary (0-12) College (1-4 or 5+) 12th 2yrs. Museum Assistant Curator Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, . Pages 1 and 2 should be file timent of Health and Mental Hy tant: If item 27 is marked oth jury or other traumatic event Be Ludwig Wlodarski Zofia Prontniczka ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Veronica Piskor /Daughter 1406 Gardman Avenue Baltimore, Md. 21209 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State November Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or St.Stanislaus Cem 20, 2010Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral 1201 Dundalk Avenue Baltimore, Md.21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS /Medical Due to (or as a consequence of) Examiner TEMMONIA Sequentially list conditions, if any, leading to immediate cause. Clusease or injury that initiated events Examiner Due o (or as a consequence of) g physician and as the burial-transit RYMAI +01 nre resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year 1 Yes 2 No Pregnant at time of death 5 Other (specify) signed by the att 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 2 No 3 Probably 4 Unknown 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy has 1 Yes 2 No 1 Tyes 2 No certificate or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 2 - No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 Other (Specify) မ this in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation М 1 Yes death. 2 Accident 24 hours after death Funeral Director: 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 - Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (check only and manner stated within 2 29b. Signature and title of certifier November 17, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 J. DISESA M.D. 31. Date filed (Month, Day, NOV 22 32. Registrar's ignatur State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Nov Day 10 Physician/ 3-40 PM M Quicke Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sa timere University of Maryland 5. Social Security Number ge (În yrs. last birthday) er 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1 2 / 0 2 / 1 9 6 0 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Months Days Hours Min. Country) 49 Director 089-54-026 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 2 should be filed within 72 hours after death with the Maryland the and Mental Hygiene.

27 is marked other than "natural", or items 23a or 28a-f shor Director 1 Yes 2 No Lindenhurst NY Suffolk 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral U.S.A. 11757 241 Kramer Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates White 3 ☐ Widowed 4 🎖 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Nassau Uni.Med.Cen Stockperson Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev ည Bridget Walsh John M. Quirke Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John M. Quirke Sr 865 County Line Rd. Amityville, NY 11701 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗆 Burial 2 💢 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) 11/18/10 Glen Burnie, MD Atlantic 561 Jerusalem Avenue 21. Signature of Funeral Service Licenses 22. Name and Address of Facility M01508 NY 11553 Hartnett F.H. Uniondale, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Intracrania disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner perTension Sequentially list conditions, Examiner to for as a consequence of if any leading to immedia cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes No 3 Probably 4 Unknown cate has been significant bases and bases and bases are should b 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes No 24a. Was an autopsy performe certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certificate: To 2 [npatient 2 ER/Outpatient 3 DOA 1 Yes Director: After this d in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at work?
1 \square Yes 28d. Describe how injury occurred 5 Pending 2 🗀 Na Investigation Accident
Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital To the Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 24 only one) 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) Novio 417693513100555 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 2120 altimore. 32 Règistrar's Signatur 31. Date filed (Month, Day, Year) State Registrar

8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM/19b, perFH, G910, 12/29/2010, WS

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Rondon Leonardo Μ. 18 2ďľo 19:40M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Calvert Calvert Memorial Hospital Prince Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 😾 M 2 🗆 F 093-12-0886 Director 88 06 Puerto Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Glen Burnie 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21060 373 Taylor Ave U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 XYes 2 No
If Yes, Give
Year or Dates. Black, White, etc ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 X Yes 2 No SpecifiPuerto Rican Buerto Rican 3 Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 7th grade Merchant Seaman Maritime Union na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thomas Rondon Sophia Muriel 19a. Informant's Name/Relationship (Type, Print) 1957 Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Felipa Bond-Daughter 273 Taylor Ave, Glen Burnie, Md 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill<u> 11/26/2010 Baltimore, Md</u> 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician/ disease or condition resulting in death) spiration neumoni'o Medical Due to or as a consequence of) Examiner Sphagi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical P.O. Box 68760 nding p. IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year s been signed by the should be detached 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Intultivency Renal Records, 1 Yes 2 No 3 Probably 4 Wunknown Enc) Stage 24b. Were autopsy findings available prior to completion of cause of death? Dementic 24a. Was an autopsy performed' Atheroscientic Cardiovascular 2 🗆 No Yes 2 N 1 🗌 Yes Be 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pendina 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours a Funeral C Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) yun-D. 50653 11-19-2010 urcina GYONL SURANT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5851-Deale Musch Rivact.

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1050 Medical 4a. Facility Name (if not institution, give street and number) County of Death 4b. City, Town, or Location of Death 4c **Examiner** If Und 24 Hrs. 8. Date of Birth (Month, Day, Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) Year) 1 🗆 M 2 🖶 Months Hours Min. **Director** Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 📉 No 10e. 10f. Zip Code Street and Number 10g. Citizen of What Country? Funeral an Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Specify: 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) Maiden Surname 18. Mother's Name First, Middle 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 20a. Method of Disposition 20b. Place of Disposition (Name of - City or Town, State Date 20c. Location cemetery crematory or other place. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) runcial Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence of, the Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Other (specify) Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 🗌 No 4 Unknown 1 Yes 3 Probably Completed After this certificate has been Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6 Other (Specify) 4 Nursing Home 28c. Injury at work? 1 □ Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 To the F only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, 32. Registrar State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36585 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER 2010 16 EVELYN ROTTMAN 11:00A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SUNRISE ASSISTED LIVING BALTIMORE BALTIMORE Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) If Under **Funeral** If Under 24 Hrs. 8. Date of Birth 1 □ M 2 👿 F Days Min. 02/11/192 Director 89 Yrs 577-20-1397 NY Usual Residence of Decedent items 23a or 28a-f shov 10a. State 10b. County with the Maryland event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** MD BALTIMORE BALTIMORE 1 Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 JOANNA COURT USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ō Completed by 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 【☐ No Specify: WHITE 3 Divorced 4 Divorced Specify. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ANALYST SOCIAL SECURITY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ JOSEPH MICHAEL **ESTHER** NOVIG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is MELVIN ROTTMAN/HUSBAND JOANNA COURT. BALTIMORE. MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 【X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH TFILOH CEMETERY 11/19/2010 BALTIMORE, MD 21. Si natura 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Poset and Death Immediate Cause (Final Physician/ MANGA Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or at a consequence of): If any, leading to immedicause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perforn 1 Yes 2 No 1 Yes 2 the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Pesidence 6 X Other (Specify 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident (Month, Day, Year) 5 Pending work 1 🗌 Yes 2 🔲 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide completed filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral D Medical Cartifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledges death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 29d. Date signed 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year State Registrar DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month osen ber -16 11.30A M Medical 10 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death TOWSON GILCHRIST HOSPICE BALTIMORE Social Security Number 7. Age (In yrs. last birthday)
71 Yrs. If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign Days Hours Min. 1 □ M 2 💢 F Months 214-38-1537 06/09/1939 Country) Director POL AND Usual Residence of Decedent 28a-f shov 10a. State 10b. County death with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE BALTIMORE 1 Tes 2XXNo ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be items 23a Funeral 31 MARY CARROLL COURT 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. or, ģ 1 Never Married 2 X Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", WHITE 3 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) e 1 and 2 should be filed within 73 of Health and Mental Hygiene. If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the INTERIOR DESIGNER INTERIOR DESIGN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည WALTER **GOL DMANN** VERAFRIEDLANDER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra PAUL M. ROSENBERG/HUSBAND MARY CARROLL COURT. BALTIMORE. MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) DHEB SHALOM MEM.PARK 11/19/2010 | REISTERSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE. 23a. Part - Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or so consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury and as the bunial-tran that initiated events resulting in death) Last Due to (or as a consequence of): ate has been signed by the attending physician page 2 should be detached for use as the buna Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 \sum Yes 2 1 No Certificate: To Pritiend 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After 1 Natural 2 Accider 5 Pending 1 Yes 2 No Accident Investigation filled in by the Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours To the Funeral I Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier Samp 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St

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State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 1<u>9</u> Physician/ Sheppard 201 4:57% Randolph November Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 313 S. East Avenue If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 5 (Month, Pay Year Maryland 218-44-0878 64 Director Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov 10b. County 10c. City, Town or Location Examiner must be notified at 10a, State Director 1 X Yes 2 □ No MD N/A Baltimore 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a Funeral 21224 USA 313 S. East Avenue 2 should be filed within 72 hours after death w th and Mental Hygiene. 27 is marked other than "natural", or items: traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) N / A Elementary/Seconday (0-12) 12 Baltimore City Solid Waste Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) (UNK) ပ Pearl Elizabeth Green I and 2 should b f Health and Mei tem 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $313\ S.\ East\ Avenue\ Baltimore,\ MD\ 21224$ 19a, Informant's Name/Relationship (Type, Print) Mary Haberkam-Companion permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other t or other 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 11-23-10 Baltimore, MD Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA 1201 Dundalk Avenue Baltimore, MD 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter e mode of dying, such as cardia or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a co Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a conseque Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter completed filled in by the funeral director, page 2 should be detached for L in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) Pregnant at time of death 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autons performed? Yes 2 K No death? 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical æ examiner? Hospital Other 2 X No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Nesidence 6 Other (Specify) 욘 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27 Manner of Death 28d. Describe how injury occurred Certificate: X Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Modical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only on 29d. Date signed (Month, Dav. Year) 29c. License number 29b. Signatur D 55625 11-19-2010 Suite 200 ompleted cause of death (Item 23a) (Type, Print) 30. Name and 9419 Common Brook Rd Owings Mills, Royck Jr. M.D.31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 36588 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Medical Examiner Daniel J. Serio Month November 18, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Bayview Medical Center **Baltimore** 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** If Under 1 Year Foreign Country) Maryland Director Months Davs Hours Min 219-07-5904 92 4-7-1918 1 M 2 F Usual Residence of Decedent any 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show e notified at once, MD Baltimore Co Baltimore 1 Yes 2 X No hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6721 Brentwood Avenue 21222 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, 1 Never Married 2 X Married Armed Forces White, etc. 1 X Yes 3 Widowed 4 Divorced If Yes, Give Year WWIT 1 Yes 2 No specify: Specify: White þ or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Pages I and 2 should be filed within 72 I Department of Health and Mental Hygiene. Important: If item 27 is marked other than " N/ALift Truck Operator American Can Co. 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) (UNK) Be Fidele Serio Josephine 19a. Informant's Name/Relationship (Type, Print) ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD Martha Serio- Wife Brentwood Avenue Baltimore, MD20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 \overline{X} Bunal 2 Cremation 3 Removal from State 11 - 22 - 104 Donation 5 Other Specify: Stanislaus Cem! Baltimore, MD 21. Signature of Funeral Service-Licenses 22. Name and Address of Facility Kaczorowski Funeral Home, PA Dundalk Avenue Baltimore, MD 21222 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death a Complications of Chronic Obstructive Pulmonary Disease Immediate Cause /Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause Due to for as a consequence of Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last ending physician and use as the burial - transi Physician/Medical AMEADED PER ME g910 12/1/10 TT UNPENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death Month Dav Year past 12 months? Pregnant at time of death 5 Other (Specify) detached for 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23e. Did tobacco use contribute to the cause of death? ģ Hypertensive cardiovascular disease 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed After this certificate has been 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed death? Yes 2 V No To the Hospital or Attending Physician: within 24 hours after death 25. Was case referred to medical Division of Vital 26.Place of Death (Check only one) Be Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other 1 🗸 Yes No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural Director: 5 Pending 1 Yes 2 No 2 Accident Investigation completely filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined To the Funeral 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 📝 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 19, 2010 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001 OCME 2006

Registrar

10-08724 Monroe D. Slick

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible [] [] State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar			Cert	ificate of	Death			Reg	. No.		
Physicia	ysician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year										. Time of Death		
Madical Exami		Monroe		aniel	Slic					November 1	14, 2010		0745 hrs
		4a. Facility Name (if no 820 East Sout	_	e street and numb	eer)	4	b. City, Town, or Frederick	r Location o			4c. County of Frederical	k	
Funeral		5. Social Security Number	ber 6. S	ex 7.	Age (In yrs. las	st birthday)	If Under 1 Yea		r 24Hrs. 8 Min.	3. Date of Birth	(MM/DD/YYYY	Foreign	
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	F	Usual Residence of De	cedent County		Idos City T	Town or Location	nn .					110	Od. Inside City Limits
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Deparment of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Director		" Toodvil	le Rd.			· ·	21771		109	U.S.A.	_	•
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nore, MD 2 ages I and 2 shou nt of Health and I tt: If item 27 is n other traumatic		20a. Method of Disposi		Removal from		ematory or oth	tion (Name of ce er place)					Location - City or Town, State	
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Division of Vital Records, P.O. Box 68 tall or attending Physician: The law requires that the death certif are death. ral Director: After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as		27. Manner of Death 1 Natural 5	Pending	28a. Date of (Month, Da	ay,Year)	28b. Time of Ir	1	ıryat Work? Yes 2 ဩ	I		winjury occurre ingest		.coho1
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Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi completely filled in by the funeral director,	Medical C	Condon only		ian: To the best o	examination and								
F. ½ Ç. Ş	Me	29b. Signature and title	of certifier	and manner state		-	29c. Licens	se number	-	2	29d. Date signe	d (Month,	, Day, Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 23410 M OIL Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 26 BaltiMore Greene 8. Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday, 24 Hrs 9. Birthplace (State or Foreign **Funeral** Min. 1 M 2 - F Hours Country) Director infant Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21230 1164 Cleveland Street USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 ☐ XNo
If Yes, Give o. Black, White, etc. 1 X Never Married 2 Married þ 1 ☐ Yes 2 🔀 No Specify: black "natural", 3 Widowed 4 Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Mea Elementary/Seconday (0-12) College (1-4 or 5+) infant infant infant Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) ပ Jasmine Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22 S. Greene Street Baltimore, MD University of MD Medical Ctr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burlal 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 □ Donation 5 Nother (Specify) in state 21. Signature of Funeral Service Licensee Ronald S. Water Director State Anatomy Board 655 W. Baltimore Street Baltimore, 21201 MD 23a. Par 1. Enter the disease, or con plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Carse (Final Physician/ Ketoem disease or condition Lavant) Medical resulting in death) Due to (or as a consequence of). **Examiner** Sequentially list conditions, cause (Disease or iinjury Dud to for as a son sequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Pregnant at time of death Day Year signed by the a d be detached for 1 Yes 2 L g Unknown g Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed' death? 1 Yes 2 No Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other: 욘 1 Inpatient 2 ER/Outpatient 3 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural
2 Accident work? 5 Pending 2 🗌 No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

DHMH 17 Rev 7/2009

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ STOT 12:30 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard County General Hospital Columbia Howard Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept 10, 1 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. 1 M 2 X F Months Days Hours Country) Massachusetts Director Sept 368-48-5009 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location death with the Maryland any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No MD Ellicott City Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral USA 5320 Dorsey Hall Drive #420 21042 items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 0 þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 X No Specify: should be filed within 72 hours aft and Mental Hygiene. is marked other than "natural", If Yes, Give 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) teaching education 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked Edith Joan Scott Edward Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5291 Mad River Lane Columbia, MD 21044 David D. Stott/son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signatu : Funeral Service Lio nsee Roma Ld Wade State and Andrew figac Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or ceart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ RO disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of) Examin Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Division of Vital Records, P.O. ed by t signed b d be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig ; page 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death?
1 Yes 2 No this certificate Yes director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **IN**0 မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending 2 No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 20ĬŨ Siu Hwa Tsien 4:45 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c, County of Death **Examiner** Montgomery Holy Cross Hospital Silver Spring Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Days Hours 10-22-1923 359-26-5919 China 87 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10d. Inside City Limits 10c. City. Town or Location filed within 72 hours after death with the Maryland 10a. State Director 1 Yes 2 No Maryland Montgomery Silver Spring 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? Funeral 3124 Grace Field Road 20904 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian 11, Marital Status Was Deceue... Armed Forces? [→] □ ves 2 🛣 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2x No Specify: Specify: Asian "natural", Completed 3 Widowed 4 X Divorced Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) other traumatic event, the Julie of California Office Manager Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic even once. 2 Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christopher Tsien 5022 Cloud Burst Hill Columbia, Maryland 21044 (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🗌 Burial 2 😾 Cremation 3 🗌 Removal from State Atlantic Crematory 11-8-2010 Glen Burnie, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Witzke Funeral Homes, Inc 5555 Twin Knolls Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Hemorrhage, Intracerebral disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury physician and the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical as the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 K No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🛛 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an **Director:** After this certificate has I in by the funeral director, page 2 s autopsy performed? 2 🗌 No 1 🗌 Yes Yes 2 X N Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 K No 잍 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural 5 \square Pending injury 1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, P.O. Box 68760 within 24 hours a To the Funeral C

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew Kundrat, M.D. 3110 Gracefield Road Silver Spring, MD 20904

Registrar

29a. Certifier (Check

only one)

31. Date filed (Month, Day, Year)

nouew

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0036716

11-6-2010

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mynthy . 20°10 12:25p M John Wesley Teter Medical 4a. Facility Name (if not institution, give street and number)
Carroll Lutheran Village 4b. City, Town, or Location of Death Westminster Examiner 4c. County of Death 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 229-14-7460 1 ■ M 2 □ F Days Hours Min Nownth, Day, 1923 CoV Orginia Director Usual Residence of Decedent 28a-f show 10a. State 10b. County be filed within 72 hours after death with the Maryland event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Bel Air Harford 1 🗆 Yes 2 💆 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral 21014 23a 633 Wallingford Rd. items ; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc. ŏ þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White "natural", Completed 3 Widowed 4 ☐ Divorced 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Courier Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev once. 2 Laura Jane Schaffer Victor Teter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 633 Wallingford Rd. Bel Air, MD. 21014 Janet Teter - daughter in law 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Evergreen Mem. Gardens Nov. 23,2010 Finksburg, MD 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. Start Celleto 11605 Reisterstown Rd. Owings Mills, MD. 21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury the burial-transi attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
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☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed should peen 24b Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 : autopsy performe 2 No 1 Yes 25. Was case referred to examiner? 26. Place of Death (Check only one) Be Other: 1 Yes မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) funeral 27. Mann T Death 28c. Injury at work?
1 Yes 28b. Time of Certificate: 28d. Describe how injury occurred After Natural 5 \square Pending injury Accident 2 🗌 No Investigation 24 hours after death Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determinad Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2. 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one and title of certifie 29b. 8ignatu 29c. License number 29d. Date sig/led (Month/ Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 2 Registrar

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 6a, per Fh. g909 11/18/10 TT/ #16a, per FH, G909, 11/22/2010, WS State of Maryland / Department of Health and Mental Hygiene Amend 16a, per 36595 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vear Boris Ts.mmerman Physician/ 3:30AM rember 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours 1 X M 2 □ F 1270571918 UKRAINE 91 Director 216-94-9302 Usual Residence of Decedent show 10d. Inside City Limits items 23a or 28a-f sho ner must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 1 🗌 Yes 2 🔀 No BALTIMORE BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21208 USA 1450 BEDFORD AVENUE, APT. 318 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status the Medical Examiner Armed Forces Black, White, etc. ō þ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use religible Die Maker

TOOL AND DIE MAKER 3 Widowed 4 Divorced "natural" Completed WHITE Year or Dates 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) INDUSTRIAL MACHINERY permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, tt Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ٩ SLAVA UNKNOWN TSIMMERMAN LEV 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1450 BEDFORD AVENUE, #316, BALTIMORE, MD RAISA TSIMMERMAN/WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) OWINGS MILLS, MD 11/18/2010 HAR SINAI CONG. 21. Signature of Funeral Service icen 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death End-Stage Dementia Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or linjury The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 perform 1 🗌 Yes 2 🗆 No Yes 2 Hospital or Attending Physician: 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 1105 \(\text{P1(F)} \) Hospital 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tes Certificate: To After this 28a. Date of injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 No hours after death meral Director: A Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check within 2 To the F 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) 1152y apahseM.D 11/17/10 DO 057 465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 Smith AV- 5-703 , Balthmore, MD . 21209 N S. Rajapakse, M. D. 31. Date filed (Month, 32. Registrar's Signature 1820 10 antre State Radia. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ ,Month 7:15 November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death BAltimore GENERA HUSPITAL Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Months Hours Director or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🕱 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 X No Specify: 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DQ NOT use retired) 15. Decedent's Education 16h Kind of Business Industr (Specify only highest grade completed) College (1-4 or 5+) Be s's Name (First, Middle, Last) 2 Name/Relationship (or Rural Route Number, City or 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) . Signature of Funeral Service Licensee and Address of Facility V Baltmore 23a. Part 1. Enter the disease disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause of each line ediate Cause (Final ase or condition Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any conditions, cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consection of (cf) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death Other (specify) Month Day Year 9 Unknown been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown certificate has been rector, page 2 shoul 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗌 No Yes 1 Yes 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 2 No ပ 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? Natural injury 5 Pending 1 Yes 2 No Accident Investigation hin 24 hours after deat the Funeral Director; 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) within To the 29b. Signature and title of certifie 29c. License number

State Registrar

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of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36597 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Physician/ Theresa Almenta Wright 7:20 a. Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 3415 Greencastle Road Burtonsville 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) Funeral If Under Days Min Months 1 DM 2 DF 08-18-1940 Director Washington 579-54-4421 28a-f shov 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits with the Maryland the Medical Examiner must be notified at Director 1

Yes 2 □ No Clinton MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a 20735 11627 Cosca Park Dr death v 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ò 1 Never Married 2 Married þ Maryland 21215-0036 hours after 1 Yes 2 No Specify: If Yes, Give Year or Dates SpecifyBlack "natural", 3 Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12th Disable Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Audrev Flood Joseph Flood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Gregory G. Wright/Son Cosca Park Dr. Clinton, MD 20735 11627 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 2^{Date} 10 1 🔲 Burial 2 😾 Cremation 3 🗆 Removal from State Riverdale,MD 4 Donation 5 Other (Specify) Riverdale Crematory 22. Name and Address of Facility Ronald Taylor II Funeral HM 21. Signature of Funeral Service Licensee 10583 Middleport Ln White Plains,MD 20695 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ metastatio disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): and transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Box 68760 the nding (as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death use 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Month Year Pregnant at time of death 5 Other (specify) the a 1 ☐ Yes 2 L 9 ☐ Unknown 9 I Unknown P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed' 2 No 1 Yes certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 2 No 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this (28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After . Natural 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death To the Funeral Directors, completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVENUE, SULE 203 31. Date filed (Month, Day, Year) State 22 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death State
Registrar 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Day Vear 3:21 PM NOVEMBER IS 4a. Facility Name (if not institution, give street and number) Weaver 4c. County of Death 4b. City, Town, or Location of Death you medical Conto Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In yrs. last birthday) Social Security Number (Month, Day, Year. Months 1 🗆 M 2 📝 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 Nes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Dayview 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Black, White, etc. 11. Marital Status Armed Forces? Whi 2 No 1 Never Married 2 Married 1 Yes 2 No Specify. If Yes. Give 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) City or Town, State, Zip Code, 19b. Mailing Address (Street and Number or Rural Route Number, 19a. Informant's Name/Relationship (Type, Print) 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition emetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 12010 Funeral 4 Donation 5 Other (Specify) towell 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Balto MU 23a. Part 1. Enter the disease, or complications that caused the the theoretical three the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Kertratan Immediate Cause (Final disease or condition resulting in death) Due to (or as a consorted ce of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examine Elevana that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23h. Was decedent pregnant Year Month Day in the past 12 months? Pregnant at time of death 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 🗌 Yes 2 🗍 No 3 🗌 Probably 4 🗹 Unknown by Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 2 🗆 No rmed 2 2 M No Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Minpatient 2 ER/Outpatient 3 DOA ပ 28d. Describe how injury occurred

attending physician and I for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 been signed by the s After this certificate has the funeral director, page 2

Physician/

Medical

Director

by Funeral

Completed

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Examiner

Funeral

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at

Physician/

Medical Examiner

Baltimore, Maryland 21215-0036

examiner? 27. Manner of Death

Natural

Accident

Suicide

Homicide

28a. Date of injury (Month, Day, Year) 5 Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

6 Could not be determined

28b. Time of

28c. Injury at 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2,224

29a. Certifier only one) 29b. Signature and title of certifie

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number

completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who

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Baltimore

Moventer 15,20,0

ZHAO 31. Date filed (Month, Day, Year) 2 2010

Eastern Ave. OM,

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Certificate:

Medical

within 24 hours after death.

To the Funeral Director: A completed filled in by the fu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UT | U Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2010 Medical Facility Name (if not institution, give street and number) City, Town, dr Location of Death 4c. County of Death Examiner NA LWOI DITA 9. Birthplace (State or Foreign Country) ge (In yrs. last birthday) If Under 8. Date of Birth (Month, Day, Year 04-04-22 **Funeral** 1 □ M 2 🏻 F 88 218-22-4897 VA Director Usual Residence of Decedent permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must he notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State rector 1X Yes 2 No MD NA Baltimore ۵ 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21216 1010 Poplar Grove Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etcAfrican 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No δ 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: American If Yes, Give 3 ₺ Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 11th Grade Homemaker Domestic Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Mae Jackson Fannie Walter Crockett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2121619a. Informant's Name/Relationship (Type, Print) 1010 Poplar Grove Street Baltimore, MD Cora Lynn Jenkins-Niece 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 A Burial 2 Cremation 3 Removal from State Zion Cemetery 11-22-10 Mt. Lansdowne, MD 4 Donation 5 Other (Specify) Wylie Funeral Home P.A. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final hysician/ disease or condition Medical resulting in death) to (or as a consequence of Examiner Secus tially list our dillors if any, leading to immediate cause. Enter Underlying Examine to (or as a conseque Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be exe Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ate has been signed by the atte page 2 should be detached for Month Year 5 Other (specify) g Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 hnknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? perform 2 🗹 No After this certificate Yes 25. Was case referred to medical 26. Place of Death (Check only one) filled in by the funeral director, To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Tes 2 1010 ER/Outpatient 3 DOA 1 Inpatient 2 28a. Date of injury (Month, Day, Year) 27. Manner eath 28b. Time of 28c. Injury at work? 1 🗌 Yes 28d. Describe how injury occurred Certificate: injury 1 L Hatural 5 \square Pending 2 🗌 No Investigation Accident after death 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 4 Homicide determined Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

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completed fil 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month,

23a) (Type, Print)

completed calise

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U 1 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 12:3) M 701 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carro OYE Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Yea Jan 13 1 Birthplace (State or Foreign Country) Social Security Number **Funeral** Days Hours Min. 1 x M 2 □ F Months 217-50-8068 62 Director 1948 Usual Residence of Decedent 10c. City, Town or Location Sykesville 10d. Inside City Limits ir than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10b. County 10a. State filed within 72 hours after death with the Maryland Director MD Carrol1 1 ☐ Yes 🎞 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 5812 Victor Drive 21784 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) information systems officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry L. Walker Jr. Augusta Kramer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon D. Walker (spouse) 5812 Victor Dr., Sykesville, MD 21784 20a. Method of Disposition
1 ⚠ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date New Cathedral Cem. 11-27-10 Baltimore, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel Signature of Funeral Service Licenses Ctypiologist & P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. The trade years Cause (Disease or iinjury Physician/Medical Examiner Due to (or as a consequence of) signed by the attending physician and deetached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) page 2 should be detached 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐ Yes 2 ☑ No 1 🗌 Yes 2 ANO hours after death.

uneral Director: After this certificate 25. Was case referred to medica To the Hospital or Attending Physician: funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Stother (Specify) Dove 1 Yes 2 40 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined Medical Secritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

24 hours a

10

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBERT RICE M.D. - 292 STONER AVE WESTMINSTER, MD 21157

31. Date filed (Month, Day, Year) State NOV 2 2 2010 Registrar

10-08594 Vincent Craig White

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death Physician/ 1. Decedent's Name (First, Middle,Last) Month Day November 9, 2010 0850 hrs **Medical Examiner** Vincent Craig White 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Hollywood St. Mary's 24494 Placid Harbor Way 8. Date of Birth (MM/DD/YYYY) If Under 1 Year If Under 24Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Director 045-48-3577 TK M 2 F 11/15/1953 CT56 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County imore; MD 21215-0036
Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once. 1 X Yes 2 No Hutchinson KS Reno irector 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. $\bar{\Box}$ 205 E. 8th Avenue 67501 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian, Black, White etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Yes Black Specify 3 Widowed Yes, Give Year Yes 2 X No specify: 4 Divorced ⋧ 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Aircraft 4+ Machinist 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lucy T. White Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) KS 67501 8th Ave., Hutchinson, <u>Doris Williams</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State Department of Important: I 11/12/10 | Hutchinson, KS Elliott Mor.& 4 Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Elliott Mortuary M01508 Hutchinson, KS 219 N Main 23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** en Onset and failure. List only one cause on each line /Medical Death Cardiac arrhythmia Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Cardiomegaly Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of). events resulting in death) Last signed by the attending physician and be detached for use as the burial - transit Physician/Medical AMENDED IIne X UNPENDED PII,27,per ME g910 12/8/10 TT To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the burit. Division of Vital Records, P.O. Box 68760, 23d Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Dav Year Fetal death Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Diabetes mellitus Completed ficate has been si page 2 should b 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of perform<u>ed</u> death? 2 No ✔ Yes 2 No 1 🗸 Yes 26 Place of Death (Check only one) 25. Was case referred to medical Be Other, Nursing Home 5 Residence 6 Other: Scene 2 ER/Outpatient 3 Inpatient 1 🗸 Yes ဥ 28b. Time of Injury 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 1 X Natural 1 Yes 2 No Pending 2 _ Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 3 [Could not be Suicide or Town, State) determined (Specify) 4 ___ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 10, 2010 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ling Li, MD 31. Date filed (Month, Day, Yea 32. Registrar's signatur State

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of	of Marylar				nd Mental H	lygiene		05500			
			State Registrar		Certificate of Death						Reg. No.2010 36602				
	Physicia	ın/	1. Decedent's Name (First, Middle Mam	. ,	Austi				2. Date of I		Year	3. Time of Death			
-	Medic Examir		4a. Facility Name (if not institution				4b. City, Town, or	Location of	Death		County of Dear				
أميناسه	=xaiiii		Johns Hopkins			enter	Ba		40	. County of Dea	ui				
	Funeral		5. Social Security Number 218–44–7033	6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of I	Birth	g. Bir	thplace (State or Foreign			
	Director		Usual Residence of Decedent	I L I M Z A	64	Yrs.	Monard Bayo	riodio	Min. (Month, May 2	2,194	6 Ker	itucky			
	and show lat	P	10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits			
	Maryl 28a-f otifiec	lect	MD		E	Baltimo	re					1 🗓 Yes 2 ☐ No			
	a or 2		10e. Street and Number				10f. Zip Code			10g. Cit	tizen of What Co	ountry?			
	th wit	Funeral Director	1039 Horner La				2120				USA				
(0	or dea	by Fu	11. Marital Status 1 ☐ Never Married 2 ☐ Marr	Armed Fo	rces?	S. 13. \	Vas Decedent of Hi f Yes, specify Cuba	spanic Origin n, Mexican, F	n? (Specify Yes or N Puerto Rican, etc.)	0-	14. Race - Ame Black, White				
980	rs afte ral", c Exan	q pa	3 ☐ Widowed 4 🔀 Divorced		∠ kA JNO e ates.	1	☐ Yes 2X No	Specify:			Specify: Wh	ite			
5-0	2 hour	Completed	15. Deceder	nt's Education st grade completed)			lent's Usual Occupa		funding	16b. K	ind of Business	Industry			
121	thin 7	Š	Elementary/Seconday (0-12)	College (1	-4 or 5+)	life. Do	O NOT use retired)		Working	,,					
d 2	ed wi Hygie other ent, tl	Be (12. 17. Father's Name (First, Middle, L	ast)		FOIK_	Lift Open		s Name (First, Middi		uminum				
Maryland 21215-0036	l be fil fental rked tic ev	မ	Dewey Gibson				İ		V. Shupe		Surname)				
lary	should and M is ma		19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailin	g Address (Street a	and Number o	or Rural Route Numi	ber, City or	Town, State, Zip	Code)			
ک,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hyglene. Important: I firem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	á	Pam Schisler /	Sister		5006	Orville	Avenu	e, Baltim	ore,	MD 2120	5			
Baltimore,	ge 1ant of H		20a. Method of Disposition 1 Durial 2 Dremation	3 Removal from	State C	emetery, crem	sition (Name of natory or other place	e) O	ctober 28		ocation - City or				
Iţi	nit. Pa artmer ortant injury		4 ☐ Donation 5 ☐ Other (S 21. Signature of Funeral Service L	pecify)	Met		matory,	INC.	2010	Bal	timore,	MD —			
Ba	Depi Impo	9	April 5 Col	120	me		EMATION I		Sever	ma Da	arle MD	21146			
			23a. P. 1. En er the disease, or s ock, or leart failure. List o	complications that of	aused the death	n. Do not ente	r the mode of dying	g, such as car	rdiac or respiratory	arrest,	ILK, MD	Approximate			
-	h,sician/	. 2	mediate Cause (Final disease or condition			Such	n 700 a	fr.	June		- 1	Interval Between Onset and Death			
	Medical Examiner	(resulting in eath)	a. Due to (or as a consequ	ience f):	n orga	h	M M C			2 hours			
		er	Sequentially list conditions,	bHy	r as a consequ							20 hours			
	red nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause Disease or injury	S			1					20 years			
	execu an and ial-tra	EX	that initiated events resulting in death) Last	C. Due to (or as a consequ	ence of):	y dise	use.							
09	death certificate be executed the attending physician and ad for use as the burial-transit	dical		d											
687	eath certifica attending ph for use as th	/Me	IF FEMALE:	200 16											
Box (ath ce attenc for us	cian	23b. Was decedent pregnant in the past 12 months?	1 Live I	come of pregnal Birth 2 Feta nant at time of d	I death 3 🗌	Ectopic pregnancy Other (specify)	/			23d. Date of del Month	ivery Day Year			
		Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 🗆 Unkn			Other (specify)					July 10th			
P.O	law requires that the nas been signed by the 2 Should be detach	by P	Part II. Other significant condition	ns contributing to de	eath but not resi	ulting in the ur	nderlying cause give	en in Part I.	23e. Did	tobacco us	se contribute to	the cause of death?			
ds,	en signal	ted							1 [Yes 2 [□ No 3 □ Pr	obably 4 🗷 Unknown			
Õ .	law re nas be s 2 sh	Completed							24a. Wa	DOSV	prior to c	opsy findings available ompletion of cause of			
ř	rsician: The law s certificate has t director, page 2 s		AF W						per 1 ☐ Yes	formed? 2 No	death?	2 🗆 No			
/ita ∷	siciar certif irecto	m	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:			Othor	`	Check only one)						
to d	g rny er this neral o	[E	27. Manner of Death	28a. Date	npatient 2	28b. Time of	28c. Injury	at	ng Home 5 Res 28d. Describe			fy)			
0	eath. or: Aft	fical	1 Natural 5 Pending 2 Accident Investig	ation	h, Day, Year)	injury	M 1 □ \	es 2□No							
Division of Vital Records,	or Au offer d directer in by t	Certificate:	3 Suicide 6 Could n 4 Homicide determin	28e. Place	of Injury - At hor g, etc. (Specify)	me, farm, stre	et, factory, office		28f. Location City or To	(Street and wn, State)	Number or Run	al Route Number,			
ַ בֿ	eral C		29a. Certifier 1 Certifying	Physician: To the be	et of my knowle	odgo dooth o	Sourced at the time	data and old		,					
3	or en rospinal or Autenting Prysician. Within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	(Check 2 - Medical Ex	aminer: On the basi Nurse Practioner: T	s of examination	and/or investig	ation, in my opinion	n death occur	red at the time date	and place	and due to the a	auco(a) and manner stated			
			29b. Signature and title of certifier												
	DA.		· V				RES	- 00	0	och	obser 2	6,2010			
- (K/3		30. Name and address of person w	ho completed cause	of death (Item	23a) (Type, Pr	int)	4.10	0	16	. 4.	0 2125//			
	State		Keiko Greev 31. Date filed (Month, Day, Year)	16 erg . 1	gistrar's Signatu	re,	castern	AVE	nue, 120	CITIM	ore, M	Day, Year) 6, 2010 D 21224			
	Registra	r	31. Date filed (Month, Day, Year) 0CT 29	2010	wa ,	8. Apr	ale								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month / 04 / 2010 8:56am M Physician/ Andrew A. Barker Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George Hospital Prince George Cheverly If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Funeral **1** M 2 □ F Days 09/28/50 Min Hours Guyana 212-63-5865 60 Yrs. Director Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State "natural", or items 23a or 28a-f sho Director Marlboro Prince George Upper 1X Yes 2 No Md 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 20774 300 Hyannis Court 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. δ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify Specify: Black Completed 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Priviate Self-Employed 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F ည Olsa Una Alexander Barker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 Hyannis Ct Upper Marlboro, Md 20774 19a. Informant's Name/Relationship (Type, Print) Genevieve Adams Wife 27 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Important: If it any injury or o Page 1 1X Burial 2 ☐ Cremation 3 X Removal from State 11/12/10 Georgetown Guyana 4 Donation 5 Other (Specify) Lepentier Cemetery 21. Signature of Funeral Service Licensee Shead Funeral Home & Cremation Service Georgia Ave NW Washington, DC20011 5732 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying burial-trape Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of attending physiciar Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) signed by the atte in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available 24a. Was an autopsy performed prior to completion of cause of death? 1 Yes 2 No 2 NO Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: ✓ Natural 5 Pending 1 Yes Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Box 68760 Division of Vital Records, P.O. filled in by the funeral director, To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After pataldmc

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1647 Benning Rd NE Ste 201 Washington, DC Norman Williamson Allen, M.D. 31. Date filed (Month, Day, Year) State 05 Registrar

Tertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

Medical

29a. Certifier

(Check

only one) 29b. Signature and title of cert

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 2<u>010</u> Month Physician/ 6:40 рМ Nov. 01ga Martha Calvr Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** Montgomery Spring Silver 2924 Birchtree Lane 8. Date of Birth (Month, Day, 1) Aug 24 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Country) Austria **Funeral** Min. Days Months Hours 1 M 2 XF 67 Aug Director 577-70-0060 Usual Residence of Decedent 10d Inside City Limits 28a-f show 10b. County 10c. City, Town or Location 10a. State or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Silver Spring 1 Yes 2 XNo MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA Funeral 20906 2924 Birchtree Lane Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. ģ XXNever Married 2 Mamied White Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: If Yes, Give Year or Dates Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Cleaning Custodian Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be file h and Mental F 7 is marked of Donna Havrisuk ည Larry Calyn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 11600 Nebel Street, Rockville, MD 20852 Laurian Fasano/Social Worker 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Nov. 5 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crematory 2010 Alexandria, VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility Francis J. Collins Funeral Hom 500 University Blvd. W, Silver 21. Signature of Funeral Service Licensee Inc. Spring, MD Part 1. In the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Leukemia Physician/ disease or condition) Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events burial-tran and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Year 5 Other (specify) signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has 1 ☐ Yes 2 ☐ No Yes 2 KNo completed filled in by the funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ After this 28a. Date of injury (Month, Day, Year) 28b. Time of Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 24 hours after death. work? 1 ☐ Yes 2 ☐ No 1XXNatural 5 Pending 2 Accident
3 Suicide Investigation
6 Could not be Director 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29c. License numb d title of certifier 29d. Date signed (Month Day Year) 29b. Signatur D25085

file

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of person who

Penny
31. Date filed (Month)

Bisk,

MD

201

Barker

40301 Georgia Avenue, #301, Silver Spring,

MD 20902

npleted dause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month JOVEMBER 12:40 AM Rav Gene Clark Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 **X**M 2 □ F Days Hours (Month, Day, Year) 5/12/1942 Pennsylvania 179-32-9910 68 Usual Residence of Decede 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No PA Franklin Scotland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3892 Lincoln St. 17254 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 ☐ Yes 2 X No Specify. 3 Divorced 4 Divorced Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Forklift Operator Paper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ Clayton Clark Myrtle Parson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clark / Wife Carol 3892 Lincoln St. Scotland, PA 17254 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Smithsburg Crematory 11/9/2010 Smithsburg Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final nset and Death neum onta disease or condition resulting in death) Obs/metive Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to jor that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by hibrilletion 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of eause of death? 24a. Was an autopsy performed?

Yes 2 No 1 Tes 25. Was case referred medical æ 26. Place of Death (Check only one) examiner? Hospital 1 Yes Other: ျ 1 Inpatient 2 ER/Outpatient 3 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation Could not be

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

Funeral

Director

28a-f shov

iral", or items 23a or 28a-f sho Examiner must be notified at

ner than "natural", ເ t, the Medical Exam

permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumation.

Physician/

) Medical Examiner

> as the burial-transit and

use

for

should be detached

peen

signed by the attending physician

Baltimore, Maryland 21215-0036

ours after death.

eral Director: After this certificate has filled in by the funeral director, page 2. Hospital within 24 hours

To the Funeral 5 State

3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of D47288

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) balMO

NOV O

128

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36606 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ No∜ember 3^{pay} 2010^{ear} Salvador Castillo 11:43 Ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 ★ M 2 🗆 F Days Hours 219-37-3207 08/14/1942 **Director** 68 Philippines Usual Residence of Decedent 28a-f shov 10a. State 10b. County ural", or items 23a or 28a-f sho Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes XXXVo Maryland Charles Waldorf 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3463 Barberry Place Unit B 20602 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: "natural", 3 Widowed 4 Divorced Completed Filipino the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Postman permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygier Important: If item 27 is marked other t any injury or other traumatic event, the once. vears U.S. Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) မ Melicio Castillo Felisa Camposano 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruiz Castillo / Son 10710 Featherstone Dr. Ft. Washington, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 11/12/2010 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cem. Clinton, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home PA Funeral Septoe Licet 6160 Oxon HIII Rd. Oxon HIII, Maryland 23a. Part L. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) most Medical Due to (or as a confequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Litter Underlying Cause (Disease or linjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Neuronath signed by the attending physician and d be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ours after death.

eral Director: After this certificate has filled in by the funeral director, page 2. autopsy performed? Yes 2 1 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital: 1 🗆 Yes 2 No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 400704 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUOR du 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

ach

State of Maryland / Department of Health and Mental Hygiene, for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Ochober 28,2010ear Physician/ 2:30 P Irene G. Drenker Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Crofton Care and Rehab Crofton Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 0140994927 Puraho 518-24-3731 83 **Director** Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 72 hours after death with the Maryland Director 1 🗌 Yes 2 🖵 No PA Chester Downington 10f. Zip Code 10g, Citizen of What Country? 10e Street and Number Funeral 101 Plaza Drive Apt.247 19335 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Was Deceuding
Armed Forces?

1 Yes 2 No
Give X Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates "natural", Completed 3 Widowed 4 Divorced other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Department of Health and Menta Inportant: If item 27 is marked any injury or "." 2 Theodore Kirsch Maude Botterill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven G. Drenker 265 Avalene Drive Los Altos, CA 94022 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Paul Cemetery 11/02/2010 Exton, PA 19341 Signature of Funeral Service Licen 22. Name and Address of Facility 12 Ridgely Ave Annapolis,MD 21401 Hardesty Funeral home P.A. Approximate
Interval Between
Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 wonths?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has certificate 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of nours after death.

neral Director: After the filled in by the funeral 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending work? 2 No Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. npleted (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🖂 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and tole of certifier 29d. Date signed (Month, Day, Year) 3/2 address of person who completed cause of death (Item 23a) (Type, Print) Defense Hux, Crofton, MD21114 rav 31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

State

Registrar

NOV 0 1 2010

Box 68760

P.0.

Records,

of Vital

Division

NOVEMBER 4, 2010

		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
4	For	State of Maryland / Department of Health and Mental Hygiene

	_	For State Registrar		State of Mar	yland /		artment tificate				ientai my	Reg. No	71111	36608	
Physicia Medic		1. Decedent's Name Sebastiana	e (First, Middle, Last) a Maria Do								2. Date of De Month November		2010 Year	3. Time of Death 1:00 p M	
Examine		4a. Facility Name (if n	, ,	treet and number)			4b. City, To		ocation	n of Death		40	c. County of Dea Montgome		
Funeral Director		5. Social Security Nut 216–04–2624	4 1 -	7. Age (In	In yrs. last bir 3	rthday) Yrs.	If Under 1 Months		If Unde Hours	er 24 Hrs. Min.	8. Date of Bir (Month, Da Dec. 10,	av. Year)	Co	rthplace (State or Foreign ountry) z.il	
faryland Ba-f show tified at	ector	Usual Residence of D 10a. State MD	Decedent 10b. County Montgomer		-	y, Town or Location .lver Spring							10d. Inside City Limits 1 ☐ Yes 2 🔀 No		
with the N s 23a or 28 sust be not	Funeral Director	10e. Street and Numl 4208 Isbel				10f. Zip Code 10g. Citizen of Wh 20906 USA							ountry?		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Merfall Hylgiene. Important: If time Z7 is marked other than "natural", or items Z3a or Z8a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 1 ☐ Never Marrie 3 ☑ Widowed 4	ed 2 Married	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.			Vas Deceder f Yes, specifi Yes 2				cify Yes or No- Rican, etc.) lian	-	14. Race - Ame Black, Whit Specify: Whi t	te, etc.	
within 72 hour giene. er than "natu , the Medical	Completed by	Elementary/Secon	15. Decedent's Edu cify only highest grad onday (0-12) one		-17	(Give kind of work done during most of working life. DO NOT use retired)						Kind of Business Own Home	nd of Business Industry		
J be filed v Aental Hyg arked oth	To Be	17. Father's Name (Fi	First, Middle, Last) Claudio Dos	Santos				- 1			e (First, Middle Conceica		i Surname)		
d 2 should lath and N n 27 is male er trauma			me/Relationship (Type os Santos/So				-				l Route Number		or Town, State, Zi	p Code)	
Page 1 an nent of He ant: If iten ury or oth			osition Cremation 3	Removal from State	ery, crem	position (Name of matory or other place) aven Cemetery 2010 20c. Location - Construction and Park 2010 20c. Location - Construction - Construc						Location - City or			
permit. Departn Importa any inji		21. Signature of Fund	eral Service License	inlo		22. Fr 500	Name and rancis Unive	Address J. Co rsity	of Faci 11in Blv	ility IS Fune Id. W.,	ral Home Silver				
nysician, Medical		Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple embelic stvekes Due to (or as consequence of): Stvekes vivid ans ends cardiation The consequence of the consequence of the cardiate of the cardiate of the consequence of the cardiate of the												Approximate Interval Between	
Examiner	er	Sequentially list con-	nattions,	Due to (or as a co	onsequence	of):	lans	er	ndo	car	ditis			10 da 45	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	sal Examiner	if any, leading to immoduse. Enter Underly Cause (Disease or iit that initiated events resulting in death) La	injury c	Due to (or as a co	,	ience of):									
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the death ce by the attence ached for us	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)									23d. Date of de Month	elivery Day Year			
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The law recate has be page 2 sho	Completed	sepy	15								_ perf	s an opsy formed? : 2 6 N	prior to death?	utopsy findings available completion of cause of	
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rding Physi th. : After this c e funeral dir	icate: To	1 ☐ Yes 2 ☐ 27. Manner of Death 1 ☒ Natural 2 ☐ Accident	20110	1 A Inpatient 28a. Date of injury (Month, Day, Ye	28b.	Outpatient Time of injury		A Other: ic. Injury at work? 1 Ye	_4 <u> </u>	2	me 5 Resi		6 Other (Spec ry occurred	eify)	
al or Atter s after dea al Director ed in by th	al Certificate:	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Injury building, etc. (S		arm, stre	et, factory,	office		2	28f. Location (City or To			ural Route Number,	
ne Hospit in 24 hour he Funera	Medical	(Check 2	Medical Examine	cian: To the best of my er: On the basis of exam Practioner: To the bes	nination and/o	or investi	igation, in my	ny opinion,	, death o	occurred at	the time, date	and place	e, and due to the	cause(s) and manner stated.	
To the Com		29b. Signature and tit	tle of certifier ani L	Dime	h.	Mi	0	License no	044	+13		NOV	ate signed (Mont	4,2010	
,		Juanito	a L. Smi	impleted cause of death	9901	(Type, Pi	rint) edicorl	Len	1 ter	Dir.	Rock	kvill	e, Mar	yland 20850	
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DHMH 17 Rev 7/2009

Registrar

05 2010

State of Maryland / Department of Health and Mental Hygiene 0 10

for State Registrar Certificate of Death Rea. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NOV -Physician/ 20^{Year}0 09:45AM Birdie Mae Dinkins Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Clinton <u>Prince Georges</u> 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Social Security Number **Funeral** South 1 □ M 2 🔀 F Months Hours Min Director 89 071-26-6614 March Usual Residence of Deceden ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c City Town or Location Director 1 XYes 2 □ No Clinton MD Prince Georges 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral 20735 USA 10200 White Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2 ☐XNo Specify: "natural", Completed 3 X Widowed 4 Divorced traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Animal Caretaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental h ည Nicholas Bradford Elizabeth Campbell permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 195 Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20735 Debra Childs/Daughter Clinton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State MaryrandatoWetherans 1 🔀 Burial 2 🗌 Cremation 3 🗆 Removal from State 11/9/10 CHeltenham, MD 4 Donation 5 Other (Specify) Cemetery 22. Name and Address of Facility Austin Royster Funeral Home 21. Signature of Funeral Service Licensee Hutarco M00969 14th Street, NW, Washington, DC 20011 3821 lon 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to or as a consequence of): and -tropsit vounce that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Fue to (or as a consequence of) attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 9 Unknown P.O. þ Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Onknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 : 1 ☐ Yes 2 ☐ No Yes 26. Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be examiner? Hospital Other: 2 1 No 2 ER/Outpatient 3 DOA ၉ 1 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify, 27. Mann Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending Natural Accident within 24 hours after death

To the Funeral Director: A
completed filled in by the f Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f Location (Street and Number or Rural Route Number, ☐ Homicide determined Medical 29a. Certifier Certifying Physician:/To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) VOL ompleted cause of death (Item 23a) (Type, Print) M.D. Arasto. 30. Name and address of person wbo Yazdani cl 31. Date filed (Month, Day, Year, State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ November 7 4:15 A DiGiovanni Marguerite Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring Arden Court Assisted Living 5. Social Security Number 7. Age (In yrs. last birthday) 95 Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 - M 2X X F Months Hours 10/15/1915 Virginia 223-16-0085 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f Washington D.C. 1 X Yes 2 No D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ed other than "natural", or items 23a o event, the Medical Examiner must be Funeral 2711 33rd Street S.E. 20020 USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White If Yes. Give Completed 3 Widowed 4 ☐ Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Restaurant Self-Employed 12 years Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) ဂ္ Theresa Demma Vincenzo Pace traumatic and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 33rd Street. S.E. Washington, D.C. 20020 Tom DiGiovanni / Son item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important: If ite any injury or ot 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State Mt. Olivet Cemetery 11/10/2010 Washington, D.C. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur uneral Service Ligense 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Rd. Oxon Hill, Maryland 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line: et and Death Immediate Cause (Final Physician disease or conditi-resulting in death) Vear Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): nding physician and use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Yes 2xx No detached 9 Unknown g Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown s been significant 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law 124 hours after death.
Funeral Director: After this certificate has t autopsy performed? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 A Other (Specific Spisted Livin 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 X Natural 5 Pending 2 🗆 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

Medical

29a. Certifier

(Check

29b. Signature and title of certifier

Name and address of person who completed cause of death (Item 23a) (Type, Print) M. Q- 14201 rong 31. Date filed (Month, Day, Year) NOV 0 9 2010 32. Registrar's signatur

💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Laure PK on #102 Laurel, MD 20707

			State of Maryland / Department of Health and N 1- State Registrar Amend Items 24a, 25 per dr Og 909 11/22/2010dhb	/lental Hy	rgiene Reg. No. 0 (36613
١	Physicia	an	Decedent's Name (First, Middle, Last) HTLDA JANE DUNCAN	2. Date of De Month		3. Time of Death 9:00 A M
	/Medio		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	10	4c. County of I	
i			30 BLAIR STREET FROSTBURG		ALLEG	
Ī	Funeral		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 1 If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Bi (Month, D	ay, Year)	Birthplace (State or Foreign Country) ARYLAND
	Director		213-44-1661 66 Usual Residence of Decedent	02 21	1744 10	
	arylan show	J.	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 Yes 2 □ No
	the Ma	Director	MD ALLEGANY FROSTBURG 10e. Street and Number 10f. Zip Code		10g. Citizen of Wha	at Country?
	3a or	al Di	30 BLAIR STREET 21532		U.S.A.	
	ems 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. 14 Fyes, specify Cuban, Mexican, Puerto	pecify Yes or No Rican, etc.)		American Indian, White, etc.
30	s afte	by Fu	1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No Specify: Year or Dates:		Specify:	WHTTE
2-003p	2 hour	ted	15. Decedent's Education 16a. Decedent's Usual Occupation	ina	16b. Kind of Busin	ess/Industry
Ž	ithin 7 ne. nan "n	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	my	0177 110) (T)
7	illed w Hygie ther tl		12 HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Nam	e (First, Middle	OWN HO e, Maiden Surname)	MF
and	ld be f lental ked o ic eve	To Be		GLOTFE	LTY RAFFER	YT
ary	shou and M is mar	-	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rui			ate, Zip Code)
e, ≅	and 2 health im 27 her tra		ROBERT DUNCAN, SR. HUSBAND 30 BLAIR STREET FROSTB	Date ME	20c. Location - Cit	v or Town State
0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it is Modical Exterior must be notified at once.		1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State			
Saltimor	mit. P partme sortan r injur.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility		UNERAL HOM	
Ď	B any Del	1 (3	HIGH TOWERS THOUGHT 60 W. MAIN ST., FR	OSTBURG	G, MD 2153	32
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory	arrest,	Approximate Interval Between Onset and Death
Reports.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Purp (PET CALCEMIA			DAYS
	Examiner		Due to (or as a consequence of): MULTIPLE MYELOMA			DAYS
-	pe tis	iner	Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events D. Due to for as a consequence of). END STACE NEW DISEA.	01-		YEARLS
_	xecute and Il-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):	<u>, c</u>		
8/00,	cate be executed physician and the burial-transit	dical E	d			
		Medi	IF FEMALE:			
Š D	e law requires that the death certifi has been signed by the attending te 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		23d. Date of Month	
j.	the de	ysic	1 ☐ Yes 2PNo 4 ☐ Pregnant at time of death 5 ☐ Other (specify)			
,	s that gned b	by Pt	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			ute to the cause of death?
ecords,	equire een sk]Yes 2 □ No 3	
Š	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Completed		24a. Wa auto pen	opsy pric	ere autopsy findings available or to completion of cause of ath?
VIII	ding Physician: The I n. After this certificate ha funeral director, page		25. Was case referred to medical 26. Place of Dea]Yes 2 ☐ No
	nysicia lis cert direct	o Be	examiner? Under the control of the c	1	sidence 6 Other	(Specify)
n 01	Ing Ph After th uneral	on: T	27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Work? 28c. Injury at Work?	28d. Describe	how injury occurred	
UNISION	Attending Physician: or death. ector: After this certific by the funeral director, i	icati	2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury At home, farm, street, factory, office	28f. Location	(Street and Number	or Rural Route Number,
2	al or A s after Il Direct	Certification:	4 Homicide determined building, etc. (Specify)	City or To	own, State)	
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	Medical (29a. Certifier (Check only one) Check only one)	e, and due to the	ne cause(s) and manne, date and place, an	ner as stated. d due to the cause(s)
	To the within to the To the comple	Mec	29b. Signature and title of certifier 29c. License number		29d. Date signed (Month, Day, Year)
			V VEA DOC 6941	9	1012	7110
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CATUSSA VEA MD 1313 Nation	a I Uw	LAVAL	MD 21502
	Sta		31. Date filed (Month, Day, Year) NOV 2 2 2010 32 Registrar's Signature Leave 9. January	. 10100		
	Registr	ar	MUY GO COTO KERNE P. MANUEL			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death November 02 Physician/ 5:45a M Evelyn J. Fox Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hebrew Home Of Greater Washington Rockville Montgomery 9. Birthplace (State or Foreign Country) New York 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 🗆 M 2 🕱 F Hours 10/21/1921 579-18-7110 89 **Director** Usual Residence of Decedent important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 72 hours after death with the Maryland Director Rockville 1 Yes 2 X No Maryland Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20852 U.S.A. Jefferson St., 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces' Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify. 3 Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samuel Jawitz Anna Hefler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Page 1 and 2 1799 E. Jefferson St., #316, Rockville. MD 20852 Albert Fox - Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗌 Cremation 3 🖵 Removal from State Judean Memorial Grdns: 11/04/2010 Olney, Maryland 4 Donation 5 Other (Specify) permit. 21. Signature of Funeral Service 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Port 1. Enter th shock, or he of failure. List only one cause on Onset and Death Immediate Cause Physician/ disease or condition resulting in death) Medical Lue to or as a consequence of) Examiner ROIVARV Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed Muthin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Inneral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 4 Pregnant : 9 Unknown Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐ Yes 2 ☐ No **Division of Vital** Be Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 \square Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 018081 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RD. MONTROSE 31. Date filed (Month, Day, State NOV 05 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month October Physician/ 7:35a M 2010 Ellice Feiveson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Illinois 1 □ M 2 🗓 F Months Davs Hours (Month, Day, Year) 11/04/1942 67 Director 360-34-5180 Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 28a-f 1 Yes 2 X No Silver Spring Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 23a 20906 U.S.A. 15201 Elkridge Way. #2F Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No ō 1 Never Married 2 X Married þ 21215-0036 1 Yes 2 No Specify: If Yes, Give White "natural", 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Secretary Medical other Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be Maryland 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 Pearl Faden Sydney April 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #2F. Silver Spring. MD 20906 15201 Elkridge Way. Arthur Feiveson - Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Judean Memorial Grdns 11/03/2010 Olney, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 21. Signature of Funeral Service Licenses MD 20904 11800 New Hampshire Ave., Silver Spring, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ Increased Intracranial Pressure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Non-Traumatic Subdural Hematoma Days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) physician the burial Physician/Medical attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Pregnant at time of death 5 Other (specify) ed by the a detached f Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 🛛 No 3 🗆 Probably 4 🗆 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No has 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 Yes 2 X No 1 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ဂ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 X Natural 5 Pending work?
1 Yes 2 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature a 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road, Bethesda, Maryland 20851 Ph.D., Donald Shields. M.D.

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

NOV 05

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death October Physician/ 2010 10:24 A M Helen H. Gerrior Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 1002 Windjammer Ct. Churchton 9. Birthplace (State or Foreign Country) Tennessee Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth **Funeral** 1 M 2 K Months 6/26/1926 Director 84 220-16-7398 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No Annapolis Maryland Anne Arundel 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? Funeral USA 21403 810 Parkwood Ave., Apt. A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 X Widowed 4 □ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eva Brown George Conner Hagood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1431 Aqui Esta Dr., Unit 311, Punta Gorda, FL 33950 Sharon L. Riley/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 11/2/10 Annapolis, Maryland 4 Donation 5 Donation 5 Dother (Specify) Entombrent Hillcrest Mausoleum 21. Signatu / ral Sovice Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ cancer disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this continues that the con the attending physician and hed for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death Unknown 1 Yes 2 s been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 ☐ Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s autopsy perforn 1 Tyes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Daughter's Hospital Other: 2 XNo ျဉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural iniury work? 5 Pending 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ☐ Medical Examiner: On the basis of examination and on invosignation, in a gain of the time, date and place, and due to the cause(s) and manner as stated.

☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature an 29d. Date signed (Month, Day, Year) title of ce 71 son who completed cause of death (Item 23a) (Type, Print) of p Suite 240, Annapolis, MD 21401 M.D 2003 Medical Pkwy. Jason Taksey,

State Registrar 31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State	State of M	laryland / Depa			Mental Hyg	jiene		
			Registrar 1. Decedent's Name (First, Middle	e, Last)	Cei	rtificate of l	Death	2. Date of Dear	teg. No. 2	10	3. Time of Death
	Physicia Medic		ELLEN MARY	HUGHES				October	_	2010	3:38 P M
	Examir		4a. Facility Name (if not institution			4b. City, Town, o	r Location of Death	<u></u>	4c. County		
- And			13605 Ambassa 5. Social Security Number		ge (In yrs. last birthday)	German		8. Date of Birth		gomen	lace (State or Foreign
	Funeral Director		212-76-3343	1 □ M 2 🔀 F	53 Yrs.	Months Days	Hours Min.	(Month, Day, March I	6,1957	Count	Maryland
	ow Jak	_	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation					Od. Inside City Limits
	farylar 3a-f sh iffied a	Director	Maryland Montg		Germant						1 ☐ Yes 2 🛣 No
	the Na or 28		10e. Street and Number			10f. Zip Code			10g. Citizen of V	What Count	try?
	th with ms 23	Funeral	13605 Ambassad			208			U.S.A		
21215-0036	e 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at.	2	11. Marital Status 1 ☐ Never Married 2 🛣 Mar 3 ☐ Widowed 4 ☐ Divorced	If You Cive	No	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ☒ No	lispanic Origin? (Spi an, Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)	Blac	e - America k, White, e Whit	tc.
2-0	2 hour "natu edical	plete		nt's Education est grade completed)		dent's Usual Occup	pation during most of work	ina	16b. Kind of Bu	usiness Ind	ustry
121	ithin 7; ene. • than he Me	Completed	Elementary/Seconday (0-12)	College (1-4 or 5 2 Years	5+) life. D	O NOT use retired)			Health	care	Services
197	iled will Hygin other	Be	17. Father's Name (First, Middle, I		<u> </u>	110020	18. Mother's Nam	ne (First, Middle, N			
ylar	should be file and Mental I 7 is marked o raumatic eve	욘	Andrew O'Reil	ly			Eleano	Severi	n.		
Mar	2 shou Ith and 27 is m		19a. Informant's Name/Relations Patrick F. Hug			_	and Number or Run dor Drive		-		'
ნ	f Healf f Healf item 2 other		20a. Method of Disposition	3ites/Spouse	20b. Place of Dispo	sition (Name of	- :		20c. Location -		
m0	Page 1 ment of 3 ant: If it ury or o		1 ☐ Burial 2 🖾 Cremation 4 ☐ Donation 5 ☐ Other (S		remetery, crem	natory or other place n Cremate	ory 11/02	2/2010	3rentwo	od, M	aryland
Baltimore, Maryland	permit. Page Department of Important: If any injury or once,		21. Signature of Funeral Service L	io-inse MO#1	070 - 22	. Name and Addre		ES-RINAI			HOME, INC., MD 20904
	Pnysician/		23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition	complications that caused only one cause on each line	d the death. Do not ente e.	er the mode of dyin	g, such as cardiac	or respiratory arre	st,		Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)	a. Due to (or s:	a consequence of):	I. O	1				8 years
	LAGIIIIICI	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a Jonsequence of):	ngodun	idroglan	nd		$-\!$	8 yeas
	nted Ited	Examiner	cause. Enter Underlying Cause (Disease or iinjury	Due to for as a	Unsequence on.	O	U				100
	execu ian an	al Ex	that initiated events resulting in death) Last	Due to (or as	a consequence of):						
200	icate be executed physician and strength transfer the purial transfer trans	edical	(1)	d							
Box 687	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial transfer.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	4 Pregnant a	2 Fetal death 3	Ectopic pregnand Other (specify)	ру		23d. Dat	e of deliver	ry Day Year
P.O. E	at the call by the stacke	Phys	9 Unknown Part II. Other significant condition	g ∐ Unknown	out not requiting in the u	ndorlying on on air	van in Part i	T			
	quires tha	ted by	- artii. Other significant conduct	wis contributing to death b	at not resulting in the d	ndenying cause gi	yen in Part I.		es 2 No		e cause of death? ably 4 Unknown
Division of Vital Records,	rsician: The law re s certificate has be lirector, page 2 sh	Completed						24a. Was ar autops perform 1 🗌 Yes 2	y F ned?- c		sy findings available inpletion of cause of
Ita	sician: certific irector,	Be c	25. Was case referred to medical examiner? 1 \(\sum \) Yes 2 \(\sum \)\(\sum \)	Hospital:		Oth	ace of Death (Checker:			_	
o	g Physer this eral di	e: To	27. Manner of Death	28a. Date of injur		28c. Injury	4 □ Nursing Hoy y at	ome 5 Reside 28d. Describe ho			
00	ending eath. or: Affe he fun	ficat	1 Natural 5 Pendin 2 Accident Investig 3 Suicide 6 Could	gation	y, Year) injury	M 1 □	? Yes 2 □ No				
NISI	or Att	Certificate:	3 Suicide 6 Could 4 Homicide determ		ury - At home, farm, stre c. (Specify)	eet, factory, office		28f. Location (Str City or Town,		r or Rural F	Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director.		29a. Certifier 1XCertifying	Physician: To the best of	my knowledge, death o	occured at the time	, date and place, an	d due to the caus	e(s) and manne	er as stated	
	the Ho lin 24 f the Ful upleted	Medical	(Check 2 Medical E	xaminer: On the basis of ex Nurse Practioner: To the	xamination and/or invest	igation, in my opinio	on, death occurred at	the time, date and	d place, and due	to the caus	se(s) and manner stated.
			29b. Signature and title of certifier	a la la		29c. License	e number	C 25	9d. Date signed	(Month, Da	ay, Year)
	5		30. Name and address of person v	Broker	onth (Itam 22a) (Time 5	DO	06409	7 1	vovem b	er 1	2010
			TAISHEI BLAU		eath (Item 23a) (Type, P	N3 UNIVE	RSITY 1	550 00	LEANS	ST. F	BALTIMORE, M
	Stat Registra		31. Date filed (Month, Day, Year)		ar's Signature	N. J					21231
	negistra	1	1404 00	LUIU CERSON	1. 1						

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** Houle 2010 2:55 P E. Marcelle Nov. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Potomac Potomac Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Min. Months Days Hours 1 □ M 2 🖾 F Sept. 30, 1934 New Hampshire Director 003-24-3920 76 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State Yes 2 □ No MD Director Montgomery Potomac 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20854 10714 Potomac Tennis Lane USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2★No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐Yes 2√€ No Specify Specify: white ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Staff Assistant World Bank 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Houle Gabrielle M.L. Gelinas ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Bert Houle/Brother 890 Wisconsin St., San Francisco, CA 94107 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 🖾 Removal from State Nov.12,2010 Manchester, NH 4 ☐ Donation 5 ☐ Other (Specify) Mt. Calvary Cem. 21. Signature Funeral Service 22. Name and Address of Facility DeVol Funeral Home M01315 2222 Wisconsin Ave., N.W. Washington, D.C. 20007 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Complications of Metastatic Lung Cancer 1 year disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury -that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed signed by the attending physician and a be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown icate has been si , page 2 should t 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform r this certificate had raid director, page 2 X No 1 □ Yes To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2 🛣 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number omas D50534 Nov. 2, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 1313 Dolley Madison Blvd. #302 McLean, VA 22101 Thomas M. Masterson, 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar NOV 05 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Day 2010 Physician/ 9:55 р м Richard Leon HARBAUGH Nov. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1203 Virginia Avenue Washington Hagerstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Ye uly 20 1 ▼ M 2 □ F Months Hours Min. Director 218-30-7625 76 Maryland JulyUsual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. Count 10d. Inside City Limits 10c. City, Town or Location within 72 hours after death with the Maryland Director 10a, State 1 ¥ Yes 2 □ No Maryland Washington Hagerstown 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1203 Virginia Avenue 21740 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify White Specify: "natural", 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.
77 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Brakeman Railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental P Important: If item 27 is marked of any injuy or other traumatic ever once. ပ္ Unknown <u>Agnes Sophia Bryan</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Claudine Harbaugh - Wife 1203 Virginia Avenue, Hagerstown, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 11/8/10 Hagerstown, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition obstruct 20 Physician/ YLOW Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 ☐ Yes 2 ☐ Unknown Yes 2 No been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by dis was c 4rtory Division of Vital Records, 2 No 3 Probably 4 Unknown completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 1 🗌 Yes Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 1. Natural 5 - Pending 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: A Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) D65488 Name and address of person who completed cause of death (Item 23a) (Type, Print) 21742 M.D. Dale Hill Ave. Registrar's Signatur State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death Physician/ 2010 Nov. 9:45 Emma Vera HAMILTON Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Washington 405 Guilford Avenue Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Funeral Months Days Hours Min. (Month, Day, Year) ug. 23 1917 Maryland 1 □ M 2 🔯 Director 93 Aug. 220-10-3398 Usual Residence of Deceder 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location "natural", or items 23a or 28a-f sho dical Examiner must be notified at be filed within 72 hours after death with the Maryland Director 1 X Yes 2 □ No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21740 USA 1100 Connecticut Avenue 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. Specify: 3 Divorced Year or Dates th and Mental Hygiene.
27 is marked other than "natur traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Owner Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Samuel Barr Blanche Rose Miller t. Page 1 and 2 should be rtment of Health and Men rtant: If item 27 is marke jury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dianna Rivera - Daughter 405 Guilford Avenue, Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or otl once. 1 X Burial 2 Cremation 3 Removal from State Cedar Lawn Mem. Park 11/9/10 Hagerstown, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final cerebrovascular accident Physician/ disease or condition / Medical resulting in death) Due to (or as a consequence of) Examiner theroscleros Sequentially list conditions, Examiner if any leading to immedicause. Enter Underlying Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) 9 Unknown Division of Vital Records, P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should b 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an nas autopsy page performed 2 🗆 No certificate Yes 2 🔽 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 1 ☐ Yes 2 ☑ No မှ 1 Inpatient 2 ER/Outpatient 3 IDOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 1 Natural 5 Pending work' within 24 hours after death.

To the Funeral Director: Al
completed filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 🗹 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Centrea Kuther - Sand no November 5, 2010 Hospice of Woshington County, 7+7 Northern Avenue, Hagerstown

State Registrar

3H-2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ynthia Kuttner Sands

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 12:35PM October 2010 Physician/ Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Washington Washington County Hospital Hagerstown 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number Sex 1 M 2 D F Dec. 17 Maryland **Funeral** Months 1931 78 215-26-6460 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If fem 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must he martical and injury or other traumatic event, the Medical Examiner must he martical and any injury or other traumatic event, the Medical Examiner must he martical and any injury or other traumatic event. 10a. State Director 1 X Yes 2 No Tampa Hillsboro 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number U.S.A. Funeral 33615 8318 West Elm St. 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Black, White, etc. Armed Forces 2 No 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 White 3 Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) US Air Force Elementary/Seconday (0-12) Pilot 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Mary Walker Ralph Emerson Hoelzer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) TN37830 115 Graceland Rd., Oak Ridge, David Hoelzer/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Smithsburg Crematory 11/6/2010 1 Burial 2 X Cremation 3 Removal from State Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) Rest Paven Funeral Chapel 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 21742 1601 Pennsylvania Ave., Hagerstown, S. Mark is that caused the death. Do not enter the mode of dying, such as cardia, or respiratory arrest se on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or compli shock, or heart failure. List only one cau Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying iro d Examiner or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 FEMALE If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part signed by 2 3 Probably 4 Unknown 2 🗌 No Completed 24b. Were autopsy findings available prior to completion of cause of death? peen 24a. Was an autopsy has performed' 2 🗌 No 1 Yes Yes 2 N this certificate 26. Place of Death (Check only one) 25. Was case elerred to medical B B Other: examiner? Hospital 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 No 횬 28b. Time Yourd 28c. Injury at work? 28d. Describe how the funeral Manner of Death Certificate: Q within 24 hours after death. To the Funeral Director: After Matural 5 Pending 1 ☐ Yes 2 ☑ No 0630 Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) MO street, factory, office Suicide jury - At home, farm tc. (Specify) 28e. Pace of 4 Homicide determined completed filled in by building

SH9+1 State Registrar

the Hospital

Medical

29a. Certifier

(Check only one

29b. Signature

31. Date filed (Month) Day

son who completed cause of death (Item 23a) (Type, Print)

251

Medical Examiner: On the basis of exam Certifying Nurse Practioner: To the beg

anticia

death occured at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date sign d (Morth, Day, Year)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License numbe

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2 0 1 0 Physician/ Month Robert Joseph Kennedy 11:15 a^M Nov 4. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 3402 Hallaton Court Silver Spring Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. txXM 2 □ F Hours Ma^{(Month} 2 1, Year 1925 Country)
Wisconsin 8 5 Yrs **Director** 395-12-6646 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits with the Maryland Director Montgomery MD Silver Spring 1 Yes X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20906 USA 3402 Hallaton Court hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 K Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 should be filed within 72 hours after and Mental Hygiene.

is marked other than "natural", 1 Yes 2X No Specify: If Yes Give Specify: 3 Widowed 4 Divorced Year or Dates. 1943 - 60 Completed White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 4 Physicist F.D.A. other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Kennedy Caroline Ptaschinski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 1 and 2 st of Health a item 27 is June L. Kennedy/Wife Court, Si lver Spring, MD 3402 Hallaton Baltimore, Date 9, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of h
Important: If ite 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify) entonioment any injury or Gate of Heaven Silver Spring, 2010 21. Signature of Funeral Service Licensee Francis J. Facility Blvd. Funeral Home e Inc. Spring,MD Home 10 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) a Cardiomyopathy vrs Medical Due to (or as a consequence of): Examiner Coronary Artery Disease vrs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): physiciar Physician/Medical Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year 2 No ed by the a Unknown 9 Unknown Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Renal Insufficiency cate has been signated bage 2 should to Completed 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 No Yes 2 🗶 No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🖾 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🛣 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 25 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number

Registrar DHMH 17 Rev 7/2009

State

KMA

31. Date filed (Month,

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· Leisure World B

Name and address of person who completed cause of death (Item 23a) (Type, Print) in A I. Feldman MD, 3305 N. Lei

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2:42 Aм Florian P. Lee 2010 October 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Annapolis <u> Anne Arundel Medical Center</u> 9. Birthplace (State or Foreign Country) Texas 8. Date of Birth Month, Day, May 5, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number Age (In yrs. last birthday) Funeral 1 🗆 M 2 🔼 F 92 Yrs. 130-20-6856 Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland Director 1 Yes 2 No Maryland | Anne Arundel Harwood 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 20776 4187 Solomons Island Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. If Yes, Give Year or Dates Specify: Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) 12 College (1-4 or 5+) Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Elizabeth Kirkpatrick George Lofton Parker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carolyn W. Wilson /Daughter 3475 Godspeed Road, Davidsonville, MD 21035 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place,
Lakemont Cemetery 1 X Burial 2 Cremation 3 Removal from State 10-30-2010 Davidsonville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home Signature of Fun 2973 Solomons Island Rd., Edgewater, MD 21037 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Pregnant at time of death 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available 24a. Was an autopsy 1 Yes 2 W Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d, Describe how injury occurred iniury Natural 5 Pending Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 4 29b. Signature and the of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Regietrar's Signature

10-08223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Donnell Lucas		State of Maryland / Department of Health and Menta 1-For State Certificate of Death		Reg. No. 2 1	0 36621
Physicia	n/	1. Decedent's Name (First, Middle,Last) Darnell Antonie Lucas	2. Date of De Month	ath Day Year	3. Time of Death
Medical Examin		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of	October 2	27, 2010 4c. County of t	2248 hrs
		PG Hospital Center Cheverly		Prince Ge	orge's
Funeral Director		5. Social Security Number 577-13-8261 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 1 Year Months Days Hours	24Hrs. 8. Date of B	/1973 F	9. Birthplace (State or oreign DISTRICT
	ŀ	Usual Residence of Decedent			Country) of Colu
v any	ı	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
yland -f shov	ផ្ទុ	Md. Prince Georges Temple Hills 10e. Street and Number 10f. Zio Code		40- 0:::	1 X Yes 2 No
215-0036 be filed within 72 hours after death with the Maryland natal Hygiene. rked other than "natural", or items 23a or 28a-f shower, the Medical Examiner must be notified at once.	Director	10e. Street and Number 10f. Zip Code 3103 Good Hope Ave. #713 20748		10g. Citizen of What USA	Country?
h with the sms 23s	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 X Never Married 2 Married Armed Forces? 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F		o- 14. Race - A White, e	American Indian, Black,
ter deat		1 X Never Married 2 Married 1 Yes, specify Cuban, Mexican, F 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:	2010 1 10011, 010.7	Specify:	black
ours afi atural' camine	핡	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kii		16b. Kind of Busin	
36 n 72 ho nan "n ical Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12 Contractor	se retired)	Washin	gton Post
-003 d withi	탉		Name (First, Middle,		gton rost
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.	Be	talenta de la composição de la composiçã	garet Ca		Walls
D 21 should and Me 7 is ma	٥	19a. Informant's Name/Relationship (Type, Print) Margaret Lucas/ mother 19b. Mailing Address (Street and Number 13103 Good Hope A			
e, M 1 and 2 Health item 2		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - Ci	•
MOF Pages nent of ant: If or other		1 Name Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: 1 Name Burial 2 Cremation 3 Removal from State Ft. Lincoln Cem.	11/3/2010	Brentw	ood, Md.
Baltimore, MD permit Pages I and 2 sh Department of Health and Important: If item 27 is important; or other traumatinjury or other traumatinjury or other traumatinjury.	Ì	21. Signature of Funeral Server Licensee 22. Name and Address of Facility	Universa	al Mortu	ary
Physician	1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as can			
Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Gunshot Wounds			Between Onset and Death
Examiner		or condition resulting in death) Due to (or as a consequence of):			
	<u>ا</u> ق	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
	<u>≣</u>	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying in Due to (or as a consequence of):			-
50, te be executed ysician and burial - transit	edical Examiner	d.			-4.
		IF FEMALE: 23c. If yes, outcome of pregnancy		22d Data of do	livon
Sox 68760, death certificate be attending physici for use as the buri	an/a	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic p	pregnancy	23d. Date of del Month	Day Year
Box e death c the atten ed for us	Physician/N	4 Pregnant at time of death 5 Other (Specify) 9 Unknown	·		l
	함	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part			te to the cause of death?
S, P quires t en sign			1Ye		Probably 4 Unknown re autopsy findings available
COFC	Completed		autor		r to completion of cause of
I Re	<u>5</u>	25. Was case referred to medical 26.Place of Death (C	1 Yes	2No1 ✓	Yes 2 No
Vita hysicia hysicia this cer	Ď	examiner?	Nursing Home 5	Residence 6 0	Other:
ding Phy	<u>.</u>	27. Manner of Death 28a. Date of Injury (Month: Day, Year) FOUND: 28b. Time of Injury 28c. Injury at Work? FOUND: 1 Yes 2 ✓ N	Subject sho	how injury occurred	
isio Atten er death rector:	gat	2 Accident Investigation Oct 27, 2010 2216 hrs 28e. Place of Injury - At home farm street, factory office building etc.		Street and Number o	or Rural Route Number, City
Division pital or Attencours after death leral Director: filled in by the	Certification:	4 ✓ Homicide Could not be determined (Specify) Local Street		State) in Place SE, Wash	
0~ 5 5		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place one) 2 V Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occur			
To th withi To th comp	ᇠᆫ	and manner stated. 29b. Signature and title of certifier 29c. License number			(Month, Day, Year)
		O.C.M.E.		October 29, 2	
	-	30. Name and address of person who completed cause of death (Item 23a)	4004	<u> </u>	
		Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2: 31. Date filed (Mopth, Day, Year) 32. Registrar's Signature	1201		
Star Registra	te i	31. Date filed (Month, Day, Year) 32. Registrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 1

2 Date of Death

		-	For State Registrar	State of Marylan	•	tificate of D			Jiene Reg. NoΩ ∩ I	0 20025	ma
	Physicia		1. Decedent's Name (First, Middle, Las Paul	t)	LeRo	ux		2. Date of Dea	er ^{Day} , 20	3. Time of Death 6:40A. M	,
	Medic Examin		4a. Facility Name (if not institution, give Mandrin House	street and number)		4b. City, Town, or Harwood			4c. County of		
Ī	Funeral Director		070 20 7177	7. Age (<i>In yrs. la</i>	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Apicath Day	8°,1924	9. Birthplace (State or Foreign France	7
	Maryland 8a-f show tified at	rector	Usual Residence of Decedent 10a. State 10b. County Maryland Prince G		y, Town or Loc vie	cation				10d. Inside City Limits 1 ★ Yes 2 □ N	
	with the I 23a or 2 ust be no	Funeral Director	10e. Street and Number 3103 Teton Lane			10f. Zip Code 20715			10g. Citizen of Wh United S		
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.		Vas Decedent of His Yes, specify Cubar		cify Yes or No- Rican, etc.)		American Indian, White, etc. White	
Baltimore, Maryland 21215-0036	vithin 72 hou liene. ir than "natu the Medica	Completed	15. Decedent's Er (Specify only highest gra Elementary/Secondary(0-12)		I (Give I	ent's Usual Occupa kind of work done di D NOT use retired) ANCI SET		-	16b. Kind of Busi	Drug Store	
land 2	d be filed v Nental Hyg Irked othe tic event,	To Be	17. Father's Name (First, Middle, Last) Yves LeRoux		•		18. Mother's Name Georgette				
, Mary	and 2 should Health and N tem 27 is ma other trauma		19a. Informant's Name/Relationship (Ty Marc G. LeRoux -s	pe, Print) ON		g Address (Street a Ceton Land				te, Zip Code)	
imore	Page 1 and ment of He tant: If iten jury or other		20a. Method of Disposition 1 ☐ Burial 2 🕅 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	emetery, cren ${\sf tropol}$		atory 11/			ia, Virgin <u>ia</u>	
Balt	permit. Depart Import any inj	8 18	21. Signature of Funeral Service Licens	orgward!	2 2	onald Address 400 Powde	Borgward er Mill_R	t Funera oad Bel	al Home, tsville,	PA Maryland 2070	05
	Pnysician/ Medical	200	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line. Metastatic a.	h. Do not ente B rain	r the mode of dying				Approximate Interval Between Onset and Death #WEEKS	
	Examiner	Į.	Sequentially list conditions,	Lung Cancer	r					4weeks	í
	cuted and transit	ledical Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or as a consequence.							
1200	cate be executed physician and sthe burial-transi	dical E	resulting in death) Last	Due to (or as a consequent d.	derice oi):						
P.O. Box 687	ath certifi attending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live Birth 2 Feta 4 Pregnant at time of c 9 Unknown	aldeath 3 🗌	Ectopic pregnancy Other (specify)	,		23d. Date Mont		
ls, P.O.	requires that the der been signed by the should be detached	by	Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	nderlying cause give	en in Part I.			ute to the cause of death?	n
Division of Vital Records,	The law req ate has bee page 2 shoi	Completed						24a. Was a autopoperfor 1 Yes	sy pri- med? de:	ere autopsy findings available or to completion of cause of ath? □ Yes 2 🎇 No	
/ital	/sician: s certific director,	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 ☒ No	Hospital:	EB/Outpatier	_ Othe	ce of Death (Check		ence 6 X Other	Assisted Livi	no
on of	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate his completed filled in by the funeral director, page	Certificate: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work?	at		ow injury occurred		
Divisi	al or Atters after de al Directo		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, stre	eet, factory, office		28f. Location (Si City or Town		or Rural Route Number,	
	the Hospita in 24 hours the Funeral	Medical	(Check 2 Medical Exami only one) 3 Certifying Nurs	sician: To the best of my knowledger: On the basis of examination or Practioner: To the best of my	n and/or invest	igation, in my opinior	n, death occurred at	the time, date ar	nd place, and due to	o the cause(s) and manner stat	ed.
	To the I		29b. Signature and title of certifier	my	w	29c. License	number 330	2	29d. Date signed (i Novemb	Month, Day, Year) er 4, 2010	
			30. Name and address of person who of Potes ECKBER6.	MA- 14300	Gallan	+ For Law	Le #110	Bour	=, mg	70715	
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 5 201	3. Registrar's Signa		led.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 2. Robert Harry Lievens 2010 11:44 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death St. Marys Hospital Leonardtown St. Mary 5. Social Security Number 8. Date of Birth (Month, Day, Dec. 30 **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1 XM 2 □ F Hours 524-58-6605 Director 62 Colorado Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Charles 1 🗆 Yes 2 🔀 No Mechanicsville 10e. Street and Number 10g. Citizen of What Country? Funeral 36806 Asher Road 20659 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces Black, White, etc. Completed by 1 X Yes 2 No If Yes, Give 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic <u>Auto Company</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Otto George Lievens Nellie June Grant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois A. Lievens Wife 36806 Asher Rd., Mechanicsville, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ^{Date} 2010 cemetery, crematory or other place) Nov. 1 🗆 Burial 2 💢 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Funeral Service Alexandria, Virginia 22. Name and Address of Facility
Williams Funeral Home, P.A.
4270 Hawthorne Rd., Indian Head, Md 21. Signature of Funeral Service Licensee M00668 20640 23a. Part 1. Enter the dis-shock, or heart fail ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (or as a consequent of): disease or condition Medical resulting in death) Examiner hyo cardial Sequentially list conditions, Examine Due to (or as a consequence of) cause. Enter Underlying tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Cther (specify) in the past 12 months? Day Yea Pregnant at time of death Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Chronic Obstructive 24a. Was an 1 ☐ Yes 2 ►No ☐ Yes 2 Mo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: မ 1 🗌 Yes 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No e Hospital or Attending Pl 124 hours after death. e Funeral Director: After tl 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 463519 and address of person who completed cause of death (Item 23a) (Type, Print) RB6+1 Jeremy D. Tucker, D.o.

Registrar DHMH 17 Rev 7/2009

State

25500 Polat

31. Date filed (Month, Day, Year)

Lookart Road

NOV 0 8 2010

SUCUS

Leonard Lun, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** prow CHR 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b., City, Town, or Location of Deat Examiner 10 Etsville anor ape 8. Date of Birth
(Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) South **Funeral** 10 M 2□F Months Days Hours 578-34-7735 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at Iver 1 Yes 2 No Directo 10e. Street and Number 10g. Citizen of What Country? Avenue tmheast Items 23a permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 any injury or other traumatic event, the Medical Exeminer must Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Stes 2 No No Ves, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) hinist abor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be DUD. ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) Silver Spring Wil 10801-B Morrow-daughter Amherst Ave. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Bunal 2 Cremation 3 Removal from State reltenham 11-16-2019 Upper Marlbone, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Wiseman Funeral Home 21. Signature of Funeral Service Lice 4710 JUTA Pl. Camp Sphings MD. 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cardionspinitory **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ambroisseule Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Cardiovascular Disease Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Mes 2 No 3 Probably 4 Unknown Completed vostatic Carcinoma 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 2 No Macnutrition death? 1 □ Yes 2□ No the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certifies 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and tipe of certifier 29c. License number 47867

State Registrar 31. Date filed (Month, Day, Year)

NOV 0 9 2010

DHMH 17 Rev 1/2001

Zuniga. 4701 Randolph Zd # ZIL, Rockille, MD, 2085Z

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

		4 27.	partment of Health and N	lental Hygie	ene no	36628
		Registrar 1. Decedent's Name (First, Middle, Last)	ertificate of Death	1	g. No.	
Physicia		IRENE S. MAGER		2. Date of Death Month NOV •	3 Day 2010	3. Time of Death 8:20 A M
Medic Examir		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	1101.	4c. County of Death	
		3656 GLENEAGLES DR. #B	SILVER SPRING		MONTGOME	ERY
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2X F 7. Age (In yrs. last birthday) 7. Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye DEC 8 9	9. Birti	nplace (State or Foreign
Director		577-72-0812 72 Yrs. Usual Residence of Decedent		DEC. 8,	1937 WEST	T VIRGINIA
/land f shov ed at	tor	10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
e Man r 28a- notifie	Director	MD . MONTGOMERY	SILVER SPRING			1 X Yes 2 No
ith th	ral		10f. Zip Code	109	g. Citizen of What Co	·
eath v tems er mu	Funeral	3656 GLENEAGLES DR. #B 11. Marital Status 12. Was Decedent Ever in U.S. 13	20906 Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	cify Yes or No-	U.S.A.	
tfer d ", or i	þ	1 L Never Married 2 L Married 1 L Yes 2 X No	1 Yes 2 X No Specify:	Rican, etc.)	Black, White	, etc.
I3-UU30 72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho Aedical Examiner must be notified at	eted	3 Wildowed 4 X Divorced Year or Dates.	edent's Usual Occupation			HITE
A 72 h an 'n Medii	Completed	(Specify only highest grade completed) (Giv.	e kind of work done during most of work DO NOT use retired)	ng	6b. Kind of Business I	
IIIG Z I Z I 35-UU30 s filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		12 ADM	NISTRATIVE OFFICE	R F	OOD & DRUC	MINISTRATION
yiand Ild be filed Mental Hy barked oth	To Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Mai	·	
nari nati	ľ	JOHN V. SPEAKS SR. 19a. Informant's Name/Relationship (Type, Print)	ling Address (Street and Number or Rura		SWEET_	Code)
		CHARLENE SPICER/SISTER 8283	,	,		
elan of He rothe		20a. Method of Disposition 20b. Place of Disp			c. Location - City or	Fown, State
L. Page trnent o trant: If		4 □ Donation 5 □ Other (Specify) CHAMBERS	CREMATORY 11-4-	-2010	RIVERDALI	E, MD.
permit. Page 1 and 5 Department of Healt Important: If item 2 any injury or other once.	, y	21. Signature of Funeral Service Licensee M00091	22. Name and Address of Facility CHAMBERS FUNERAL HO 5801 CLEVELAND AVE	ME & CRE	MATORIUM, E	P.A. 20737
		23a. Part 1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.		_		Approximate Interval Between
Physician/	01 1	Immediate Cause (Final disease or conditiona CONGESTIVE HEART	FAILURE			Onset and Death 2 YEARS
) Medical Examiner		resulting in death) Due to (or as a consequence of): CARD TOWNOD A PLAY.				E MEADO
100	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				5 YEARS
cuted nd ransit	cami	cause. Enter Underlying Cause (Disease or linjury that initiated events c.				
e exec cian ar rurial-t	dical Examiner	resulting in death) Last Due to (or as a consequence of):				
tending Physician: The law requires that the death certificate be executed tending Physician: The law requires that the death certificate be executed beath. After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit		d				
certifica anding p	M/M	IF FEMALE: 23b. Was decedent pregnant	□ Estable programav		23d. Date of deli	very
death death	Physician/Me		Other (specify)		Month	Day Year
at the detach	Phy	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
ires th	d by	DIABETES				obably 4 🗆 Unknown
e law requires has been sig ge 2 should b	plete	LIVER FAILURE		24a. Was an		opsy findings available ompletion of cause of
The lar	Completed			autopsy performe 1 Yes 2	d? death?	2 No
ysician: ysician: s certific director,	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Check	only one)		
g Phys er this o	<u>ان</u>	1 Inpatient 2 ER/Outpatient 27. Manner of Death 28a, Date of injury 28b, Time	ent 3 🗆 DOA 4 🗆 Nursing Ho	me 5 X Residence 28d. Describe how	e 6 Other (Special	5/)
Attending r death. ctor: Afte	icat	1 X Natural 5 ☐ Pending (Month, Ďay, Year) injury 2 ☐ AccidentInvestigation	work? M 1 ☐ Yes 2 ☐ No	200. 2000.120 110.	injury occurred	
or Atte fter de hirecto n by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rura State)	al Route Number,
Spital ospital obours a ineral D	Medical (29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occured at the time, date and place, an	d due to the cause(s) and manner as stat	ed.
PIVISION OF WIRD INSTITUTION WITH INSTITUTION OF TWO DOT US. For the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Mec	(Check 2 Medical Examiner: On the basis of examination and/or inversely one) Cartifying Numer Practitioner: To the Cent of my Knowledge 29b. Signature and title of certifier	stigation, in my opinion, death occurred at	e, tirid due to the ca	place, and due to the c use(s) and the reconstitution I. Date signed (Month,	itat 3d
A		I Sand & Mally mr				
F		30. Name and address of person who completed cause of death (Item 23a) (Type,	1 10030012		NOV. 4, 20	110
		SAMUEL G. MALLER, M.D. 3305		BLVD. S	ILVER SPRI	NG, MD.20906
Star Registra	40	31. Date filed (Month, Day, Year) NOV 05 2010 Registrar's Signature	while			
		No.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36629 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11-01-20 Po Charles Edward Rabbitt :30 p. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3620 Littledale Drive,#212 Kensington Montgomery 5. Social Security Number . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛣 M 2 🗆 F Months Days Hours New Jersey Director 141-16-6904 89 Usual Residence of Decedent show ould be filed within 72 hours after death with the Maryland id Mental Hygiene.

Mental Hygiene.

marked other than "natural", or items 23a or 28a-f sho marked other than "natural", and marke be notified at matic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🔀 Yes 2 🗌 No Maryland Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3620 Littledale Drive, #212 20895 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Bace - American Indian. Armed Forces?
1

Yes 2 □ No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: If Yes, Give Specify: white 3 XWidowed 4 Divorced Year or Date 1942-1945 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Computer Technician Computer Technology Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Rabbitt peorit. Page 1 and 2 should be to Department of Health and Mente Important: If item 27 is marked any injury or other traumatic e Caroline Guenther 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Anne Barth / Daughter 4844 Albemarle St, NW, Washington, DC 20016 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 X Cremation 3 X Removal from State National Crematory 4 Donation 5 Other (Specify) 11/05/2010 Falls Church, VA Signature of Funeral Service Licenses 22. Name and Address of Facility Joseph Gawler's Sons, Inc 5130 Wisconsin Ave.NW.Washington.DC 20016 23a. Part 1. Enter the disease, or complications that claused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Ventricular Fibrulation immediately Medical Due to (or as a consequence of) Examiner Atherosclerotic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence or) neral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transli Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death Other (specify) 4 ☐ Pregnant 9 ☐ Unknown 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Aortic Stenosis, Severe 2 🛛 No 3 🗌 Probably 4 🗀 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No မှ 1 XYes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? XNatural 5 Pending 2 🗆 No after death Director: / Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined 24 hours a Funeral I Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) 2 MD40216 11/04/10

Registrar

State

7625 Wisconsin Ave #101 Bethesda, MD 20814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Cullen,

Dennis A.

31. Date filed (Month, Day, Year) NOV 0 5 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	For State Of IVI	Cer	rtificate of Dea			eg. No.2010	36630
	Physicia	n/	Decedent's Name (First, Middle, Last) Eleanor M. Sanchez				Date of Deat	Day Year 2010	3. Time of Death 7:10 A M
	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Loc	cation of Death	octobe	4c. County of Deat	h
- Marie C	Francis		Mandrin Chesapeake Hospice 5. Social Security Number 6. Sex 7. Ac	e House	Harwoo	d Under 24 Hrs.	8. Date of Birth	Anne Aru	
180 50	Funeral Director		148-24-2233 1 □ M 2 🗓 F	77 Yrs.	Months Days H	lours Min.	(Month, Day,	Year) 2,1933 New	thplace (State or Foreign untry) York
	land show d at	tor	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo					10d. Inside City Limits
	e Mary r 28a-f notifie	Direc	MD Anne Arundel 10e. Street and Number	Sever	na Park				1 ☐ Yes 2 🔀 No
	with the s 23a o	Funeral Director	304 Forest Court		21146			10g. Citizen of What Co USA	untry?
စ္တ	ter death , or item aminer m		11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 2 Mideword 4 Never Married 11 Never Married 12 Never Married 12 Never Married 12 Never Married 15 Never Married 15 Never Married 15 Never Married 16 Never Married 17 Never Married 17 Never Married 17 Never Married 18 Never Married 18 Never Married 19 Never Mar	No.	Was Decedent of Hispa If Yes, specify Cuban, W	lexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White	e, etc.
00	nours a natural" ical Exa	eted	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates. 15. Decedent's Education		1 ☐ Yes 2 🔀 No S		1	Specify: What is a specify: What is a specify: What is a specify: What is a specific with the specific way.	ite
Maryland 21215-0036	thin 72 h ne. than "r ne Medi	Completed by	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 1)	(Give life, D	kind of work done durin O NOT use retired) aqer	ng most of workin	g	U.S. Gove	
1d 2	illed wil Il Hygie I other vent, th	Be	17. Father's Name (First, Middle, Last)	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		. Mother's Name	(First, Middle, N		
ylar	uld be i Menta narked	욘	Joseph Ferlanto			Angela	Loubiso		
, Mar	rd 2 shou ealth and n 27 is n er traum		19a. Informant's Name/Relationship (Type, Print) Pamela Dittmar / Daughter	I	ng Address (Street and) West Drive				o Code)
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Metro Cre	matory or other place) matory, INC	Octob 2	er 29, 010	20c. Location - City or Baltimore,	MD
Balt	permit. Depart Import any inj		21. Signature of Furnity Service Licensee	22 Ed. 49	Name and Address of rranco & Scontine I	f Facility ONS, P.A HWY,	. Sever	na Park Fu na Park, M	neral Home
	A VIII COLO		23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lin	e.	er the mode of dying, st	uch as cardiac or	respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician/ ∕ Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as	a consequence of):			METAST	ASIS	5,155. and 25aa.
	Examiner	e.	Secretary finish that the condition was	VENOUS a consequence of):	THROM BOS	515			
	uted id ansit	Examiner	causé. Enter Underlying Cause (Disease or linjury that initiated events	JRES					
1760	cate be executed physician and s the burial-transit		resulting in death) Last Due to (or as 5 T R 0	a consequence of):					
9289	ertificat ding ph	/Mec	IF FEMALE: 23c. If yes, outcome	of pregnancy				004 D-4	
Division of Vital Records, P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical		2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of de Month	Day Year
s, P.O	requires that the de been signed by the should be detached	by	Part II. Other significant conditions contributing to death the HYPOTHYROIDISM	out not resulting in the u	underlying cause given i	in Part I.	23e. Did tob	oacco use contribute to es 2 🌠 No 3 □ P	the cause of death?
ord	as been 2 shoul	Completed	DIABETES MELLITL	15			24a. Was ar		topsy findings available completion of cause of
Ř	sician: The law is certificate has birector, page 2 s		25. Was case referred to medical				perform 1 Yes	med? death?	2 No
Vita	ysicial is certi directo	To Be	examiner? Hospital:	ient 2 ER/Outpatier		of Death (Check		ence 6 🗷 Other (Spec	HOSPICE HOUSE
ou of	ttending Physi death. :tor: After this c the funeral dir	Certificate:	27. Manner of Death 1 Natural 5 Pending (Month, Date of injugate of the part		28c. Injury at work?			w injury occurred	
Jivisi	al or Atte s after de l Directo		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injuding, et	ury - At home, farm, stroc. (Specify)	eet, factory, office	2	8f. Location (St. City or Town	reet and Number or Ru , State)	ral Route Number,
	To the Hospital Within 24 hours a To the Funeral C	Medical	29a. Certifier (Check (Check only one) 1 Certifying Physician: To the best of the configuration of the configuration of the configuration of the certifying Nurse Practioner: To the configuration of the certifying Nurse Praction of the certifying Nurse Praction of the certifying Nurse Praction of the certified o	examination and/or invest	tigation, in my opinion, d	leath occurred at t	the time, date an	d place, and due to the	cause(s) and manner stated.
			29b. Signature and title of certifier M-D.		29c. License nur		2	9d. Date signed (Mont)	n, Day, Year)
	4K			death (Item 23a) (Type, F UPERIOR		BOWFE,			
	Stat Registra		31. Date filed (Month Per Per 9 2010 32. Registr	ar's Signature	back	·			

			For State	State of	Marylar		artment of tificate of	Health and		20	10	366	31
			Registrar 1. Decedent's Name (First, Middle, La	ast)			tilloate of	Death	2. Date of Dea			3. Time of	
	ysicia Medic		Dwight O. Smil	th. Jr.					Nov.	3, Day 201	. O ^{Year}	2:20	рм
) E	xamin	er	4a. Facility Name (if not institution, give		er)		4b. City, Town, o	or Location of Deatl	1	4c. Count	y of Death		
Fu	neral		Suburban Hosp 5. Social Security Number 6.		. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	h	9. Birth	place (State or	r Foreign
	ector		3/3 30 131/	11 M 2 □ F	77	Yrs.	Months Days	Hours Min.	(Month, Day Mar 18	(, Year) 3, 1933	Cour	Burma	
pu	at	or	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Loc	ation					10d. Inside City	y Limits
Maryla	tified	rect	MD Mont	gomery	Si	lver	Spring					1 🗌 Yes	2 🗗 No
h the l	be no	Funeral Director	10e. Street and Number		•		10f. Zip Code			10g. Citizen of	What Cou	intry?	
ath wit	must	uner	10611 Marga 11. Marital Status	te Road		S 113 W		20901 Hispanic Origin? (Sp	pacify Vac or No-	USA	^	an India	
perimit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene.	Examiner	þ	Never Married 2 Married 3 □ Widowed 4 □ Divorced	Armed Ford	es?	If	Yes, specify Cub	an, Mexican, Puert	o Rican, etc.)	Bla	ck, White,		
2 hou	edical	Completed	15. Decedent's (Specify only highest g		- 6	(Give k	ent's Usual Occu ind of work done	during most of wor	king	16b. Kind of E	Business Ir	ndustry	
within 7	the M	Con	Elementary/Seconday (0-12)	College 41-4	or 5+)	1	NOT use retired han i ca) L Engine	er	Federa	1 G	overnm	ent
oe filed w	vent,	Be	17. Father's Name (First, Middle, Last, Dwight Olney	Smith	Sr.			18. Mother's Na	me (First, Middle, I	Majdeg Surpan	n n		
yld be Ment	natic e	욘											
2 sho	traum		19a. Informant's Name/Relationship (Gail A. Smith					and Number or Ru gate Roa				,	2090
1 and 1 and of Hea	other		20a. Method of Disposition		20b. I	Place of Dispos	sition (Name of	1	Data	20c Location			2030
Description of the control of the co	ury of		1 ☐ Burial 2 🛣 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	cify)	state Me	tropo	litan (remator	y 2010	Alexa	ndr	ia, VA	
permit Depart	any in		21. Signature of Funeral Service Lice	Cole				ess of Facility T Collir ersity F			me : ver	Inc. Sprin	g,MD
			23a. Part 1. Enter the disease, or con shock, or heart failure. List only, Immediate Cause (Final	nplications that ca one cause on eacl	used the deat h line.	h. Do not ente	r the mode of dyi	ng, such as cardiac	or respiratory arre	est,		Approximate Interval Betw Onset and D	veen
	dical		disease or condition resulting in death)	_ a	ras a consequ	cites					-	Onder and D	
Exan	niner		Sequentially list conditions	·		astas	is						
p	it.	nine	Sequentially list conditions, if any, leading to immediate	,	r as a conseq								
xecute	s the burial-transit	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last		ras a conseq		al Cel	l Carcir	oma				
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the de	ached	hysi	9 Unknown	9 🗌 Unkno									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Of the Funeral Director: After this certificate has been signed by the attending physician and	uld be det	by	Part II. Other significant conditions Hypoalbumine	-		-				bacco use con es 2 🗌 No			-
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The licate h	r, page		05 M						perfor 1 Yes		death? 1 Yes	2 🗆 No	
sician	irecto	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒No	Hospital:	nationt 2	ER/Outpatient		Place of Death (Che	ok only one) Iome 5 Resident		(Oif		
ng Phy	neral c		27. Manner of Death 1 📉 Natural 5 🗌 Pending	28a. Date of		28b. Time of injury	28c. Inju	ry at	28d. Describe ho			<i>y)</i>	
tendir death. tor: Af	the fu	Certificate:	2 Accident Investigation	on be	_		M 1	Yes 2 No					
tal or Atrical safter of all Direct	ed in by		4 Homicide determined	28e. Place o	f Injury - At ho g, etc. <i>(Specif</i>)		et, factory, office		28f. Location (Si City or Town		er or Rura	il Route Numbe	эr,
he Hospi in 24 hou he Funer	pleted fill	Medical	29a. Certifier 1 Certifying Ph (Check 2 Medical Examonly one) 3 Certifying Nu	niner: On the basis	of examinatio	n and/or investi	gation, in my opini	ion, death occurred	at the time, date ar	nd place, and du	e to the ca	ause(s) and man	ner stated.
V Vith	LOO LO	-	29b. Signature and fine of certifier				29c. Licens	CUGXYC)		29d. Date signe			
2	世		30. Name and address of person who	completed cause	of death (Itan	23a) (Tuna D	rint)	0065701			11/03	lalla	
10+1			Jesus Davić	d Guevai	ra-Nie	eto, M	D 86	00 01d (Georget	own Ro	oad,	Bethe	sda,
Re	Stat egistra		NOV 05 201	10 Servi	JISLIAI'S SIGNA	ure Aav							

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	_		Registrar 1. Decedent's Name (First, Middle	(act)		Cer	tificate (or Dea			rog. Hope	10	
	nysicia Medic		Emma TAylor	, ,	ough					2. Date of Dea		Year	3. Time of Death 12.00 a ^M
	xamin		4a. Facility Name (if not institution				4b. City, Tov	wn, or Loca	ation of Death			nty of Death	
1			Harrison Sen	ior Liv	ing		Snow	Hil:	1		Wor	cest	er
	neral ector		5. Social Security Number $215-36-0359$	6. Sex 1 \(\text{M} \) 2 \(\forall \) F	7. Age (In yrs. Ia 90	ast birthday) Yrs.	If Under 1 \ Months D		Under 24 Hrs. ours Min.	8. Date of Birth (Month, Day 2 / 7 / 19		Coun	place (State or Foreign stry)
			Usual Residence of Decedent							2///19	120	MD	
land	shov d at	후	10a. State 10b. County		10c. City	, Town or Loc	ation					1	10d. Inside City Limits
Mary	28a-f otifie	irec	MD Worce	ster	Snow	v Hill							1 ☐ Yes 2x No
h the	Sa or be n	al D	10e. Street and Number				10f. Zip Co				10g. Citizen o	of What Cour	ıtry?
th wit	ms 2: must	Funeral Director	266 S. Washi			lao ia	2186				USA		
er dea	or ite	by Fu	11. Marital Status1 ☐ Never Married 2 【▼ Mare	Armed F	cedent Ever in U.S Forces? s ≱ √□ No		Yes, specify	Cuban, Me	nic Origin? (Spe exican, Puerto I	city Yes or No- Rican, etc.)		ace - Americ lack, White,	
rs affe	ral", Exan		3 Widowed 4 Divorced	If Voc C	iive	1	☐ Yes 2 🎗	No Sp	pecify:		Spec	ify: Whi	te
5 houl	"natu dical	plet	15. Deceder (Specify only highe	nt's Education	d)		ent's Usual O		n g most of workli	ng I	16b. Kind of	Business In	dustry
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yland Ild be filed Mental Hy	rked i	2	George Walte		r				va War		raidon Carria	moy	
Mary 2 should Ith and M	s ma tumat		19a. Informant's Name/Relationsh			19b. Mailin	g Address (St		Number or Rura		City or Town	, State, Zip (Code)
y M	n 27 i er tra		Flora Britti	ngham/D	aughter	1635	Buck	к Наз	rbor R	d., Po	comok	e, M	21851
Ore Toffar Toffar	or oth		20a. Method of Disposition 1 Burial 2 □ Cremation	3 🗆 Removal fro		lace of Dispos emetery, crem			С	ate	20c. Locatio	n - City or To	own, State
Saltimore, bermit. Page 1 and Department of Hea	rtant:		4 Donation 5 Other (S	pecify)		inghi			11/3	/2010	Girdl	etre	e, MD
Baltimore, Maryland 21213-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	any ir		21. Signature of Fundral Service L	gensee Quality		110	Name and A	ddress of	Facility Bu m St.,	rbage Berli	Funer	al Ho	ome 11
			23a. Part 1. Enter the disease, or	complications that	t caused the death								Approximate
- Physi	ician/		shock, or heart failure. List of Immediate Cause (Final disease or condition	rily one cause on e	acri line.	: c. Q	Lis						Interval Between Onset an Deav
	edical miner		resulting in death)	a. Due to	o (or as a consequ	ence of):	11/						~ 11/3
Exai	7	7	Sequentially list conditions,	b. ———	Names of the State	SOLUTION OF						_	
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e death the affect	thed for	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pre 9 ☐ Un	gnant at time of de known	eath 5 ∟	Other (special	fy)				VIOLITI	Day Teal
that the contract of the contr	detac		Part II. Other significant condition	ns contributing to	death but not resu	ulting in the ur	iderlying caus	se given in	Part I,	23e. Did to	bacco use co	ntribute to th	ne cause of death?
uires u	ald be	ed b	Renal +	ailur	e He	ule)				1 □ Y	es 2 No	3 🗌 Prol	bably 4 🗆 Unknown
e law requires	2 short	plet								24a. Was a		o. Were auto	psy findings available mpletion of cause of
The la	page	Completed by								perfor	med?_	death?	
VICAL ysician:	ector,	Be	25. Was case referred to medical examiner?	Hospital:			2		of Death (Check	only one)			
Physi	ral dire	욘	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 [Inpatient 2 E	ER/Outpatient		Other: 4	Nursing Hor)
iding Th.	fune	cate	1 Natural 5 Pendin 2 Accident Investig	g (Mo	nth, Day, Year)	injury		work?		8d. Describe ho	w injury occi	urrea	
al or Attending P s after death.	by the	Certificate:	3 Suicide 6 Could	not be 28e. Place	e of Injury - At hor	me, farm, stre				28f, Location (St		nber or Rural	Route Number,
talor rs afte	led in			build	ding, etc. (Specify)					City or Towr	n, State)		1
DIVISION OF VICE THE HOSPITAL SHOULDS, F.O. BOX 08/00 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. The final Emeral Director After this certificate has been sinned by the attending physician and	to the Fulled in Discust. After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as it	Medical	(Check 2 Medical E	Physician: To the xaminer: On the ba	asis of examination	and/or investi	gation, in my	opinion, de	eath occurred at	the time, date an	d place, and	due to the car	use(s) and manner stated.
o the	omple		only one) 3 L Certifying 29b. Signature and title of certifier	Nurse Practioner	: To the best of my	knowledge, d		ense num			cause(s) and 29d. Date sign		
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		ŀ	30. Name and address of person	vho completed cau				6.	750	1/11/16	0,	7 0	(00)
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DHMH 17 Rev 7/2009

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Year

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

NOV 0 5 201

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First, Middle, Last) 2 Date of Death Month Sigler James 16:06 Novembe 2010 06 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore The Johns Hopkins Hospital **Baltimore City** 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 3 7 If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Social Security Number 9. Birthplace (State or Foreign 219-34-6091 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Washington Hagerstown 1 ☐ Yes 2X No 10f. Zip-Code 10g, Citizen of What Country? 10e. Street and Number 16605 Fairview Road 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 → 58 − 1 → 765, Give Year or Dates: 1964 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Specify White 1 ☐ Yes 2 XNo 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) truck mfg.co College (1-4 or 5+) Elementary/Secondary (0-12) assembly worker 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Thomas Sigler Evelyn Elizabeth Hawkins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen A. Sigler wife 16605 Fairview Rd. Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place)
Rocky Gap Cem. 20a. Method of Disposition 20c. Location - City or Town, State 11-^{Date}0-1 XBurial 2 Cremation 3 Removal from State Flintstone, MD 4 ☐ Donation 5 ☐ Other (Specify) 2010 21. Signature of Funeral Service Licenses Donald Edwin Thompson Funeral Home, Inc

Physician /Medical **Examiner**

and

signed by

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

items 23a or 28a-f s ner must be notified

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"natural",

the Medical

Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Monce.

Directo

Funeral

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Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

the burial-tran ie Hospital or Attending Phys n 24 hours after death. ie Funeral Director: After this o oletely filled in by the tuneral di

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

	23a. Part 1. Enter the disease, or compli	cations that caused the death. Do not enter the		r respiratory arrest,	g, MD 2	Approximate
	shock, or heart failure. List ofly on Immediate Cause (Final disease or condition resulting in death)	a. Is the wic caldio Due to (or as a consequence of):	myopathy			Interval Between Onset and Death
miner	Seque flow list or ditione, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):	"Disease			
lical Exa	that initiated events resulting in death) Last	Due to (or as a consequence of):				
by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		opic pregnancy er (specify)		23d. Date of deli Month	very Day Year
ed by PI	Part II. Other significant conditions con	ntributing to death but not resulting in the under	lying cause given in Part I.		use contribute to	the cause of death?
Completed				24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of 2 No
Be (25. Was case referred to medical examiner?		26. Place of Death	(Check only one)		
မ		lospital: 1 Inpatient 2 ER/Outpatient 3		e 5 Residence		ify)
ation:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury N	Work?	8d. Describe how inj	ury occurred	
Medical Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At home, farm, street, fa building, etc. (Specify)	actory, office 2	8f. Location (Street a City or Town, Stat		ral Route Number,
dical (29a. Certifier (check only one) 1 Certifying Phys 2 Medical Examin	sician: To the best of my knowledge, death occurrence: On the basis of examination and/or investig and manner stated.	urred at the time, date and place, a gation, in my opinion, death occurre	and due to the cause ed at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
Me	29b. Signature and title of certifier		29c. License number	29d. D	ate signed (Month	, Day, Year)

RES-000

State Registrar

OH 10+

ebecca Dav. Year NOV 0

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Mont)

600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

November Olo 2010

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Maryland / E	Certificate of		Reg. No.	36635
	Physicia	an	1. Decedent's Name (First, Middle, Last)			2. Date of Month		3. Time of Death
	/Medic			ks Singletary		Novemb		
	Examin	er	4a. Facility Name (If not institution, give	· ·		r Location of Death	4c. County of	Arundel
	Funeral		Anne Arundel Me 5. Social Security Number 6. Sex		thday) If Under 1 Year	apolis If Under 24 Hrs. 8. Date of		. Birthplace (State or Foreign
	Director		431-72-8419]M 2⊠F 64	Yrs. Months Days	Hours Min. (Month, Jan.]	12, 1946	Arkansas
	and ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	n or Location			10d. Inside City Limits
	Maryl	tor	DC		,	Washington		1∭XYes 2∐ No
:	r 28a	Director	10e. Street and Number		10f. Zip Code	masii ii ii geen	10g, Citizen of Wha	at Country?
3	th with	al D	3430 Pennsylvania	Avenue SE		20020	Unit	ed States
	r dea	Funeral		12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H If Yes, specify Cub	lispanic Origin? (Specify Yes or an, Mexican, Puerto Rican, etc.)	No- 14. Race - Black,	American Indian, White, etc.
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important; I flem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Moderal Examinations any injury or other traumatic event, I'm Moderal Examinations.	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1	1 ☐ Yes 2 🛣 No	Specify:		Black
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7	Hygie Hygie ther t	ပ္ပိ	17. Father's Name (First, Middle, Last)	5+ 50	enoor Counse	lor/Missionary 18. Mother's Name (First, Midd	Goveri	iment
a a	d be ental	To Be	St. Clair	Parks		Hazel		
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ž :	and 2 salth a 27 is er tra		Ryan Lucas Single	etary - Son 13	391 Pennsylv	ania Avenue SE	Unit 356 N	WDC 20003
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	20b. Place of cemeter	f Disposition (Name of ry, crematory or other place	November 6	20c. Location - Ci	
ב ב	meht meht tant: I		4 □ Donation 5 □ Other (Specify)	Georg	ge Washingto	on 2010	Adelphi	, Maryland
Baltimore,	permit Depar Impor any in once.		21. Signature of Funeral Service License	My John M.	22. Name and Addre	^{ss of Facility} Stewart Ing Road NE Wa	Funeral Haranshington.	
			23a. Part 1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death. Do r				Approximate Interval Between
May P	hysician	i y	Immediate Cause (Final disease or condition	T	1 Haran	· hi a		Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence of		``		() ()
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6876U	death certificate be executed e attending physician and d for use as the burial-transit			l				
8	a go	Medical	IF FEMALE:					-
X P P	attendir for use	jan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death		:y	23d. Date of	
S	the a	Physician/	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ☐ Pregnant at time of death 9 ☐ Unknown	5 ☐ Other (specify) _		-	,
רֻ <u>וְ</u>	ned by detar		Part II. Other significant conditions con	stributing to death but not resulting in	n the underlying cause giv	ren in Part I. 23e. D	id tobacco use contrib	ute to the cause of death?
Kecords,	as been signed by the 2 should be detached	ed by				1	☐ Yes 2 ☐ 10 3	☐ Probably 4 ☐ Unknown
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r g	D — D	mo				pe	erformed? dea	ath?
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01	this c		1 ☐ Yes 2 ☐ No		itpatient 3 DOA Oth	4 □ Nursing Home 5 □ H		(Specify)
ט ויי	ning Fritsicians After this certific funeral director,	jon:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending		Fime of 28c. Injury Wor		be how injury occurred	
UIVISION Let Attending	Attending Physicians or death. ector: After this certific by the funeral director.	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, far		Yes 2 □ No 28f. Location	n (Street and Number	or Rural Route Number,
ה ה	s after	Certification: To	4 Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)	,,,		Town, State)	
4	hour hour inera	Medical (29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examination	sician: To the best of my knowledge ner: On the basis of examination and and manner stated.	e, death occurred at the ti nd/or investigation, in my	me, date and place, and due to opinion, death occurred at the tin	the cause(s) and mani ne, date and place, an	ner as stated. d due to the cause(s)
3	24 E E		/	and marmer stated.	29c. Licens	e number	29d. Date signed (Month Day Voor
o the Los	within 24 Fo the Fi	Mec	29b. Signature and title of certifier		J.			Month, Day, rear)
To the U.	within 24 hours after death. To the Funeral Director; Completely filled in by the filled i	Mec	29b. Signature and title of certifier	504	Hua-	0482	11/01	II O
To the Une	within 24 within 24 To the Fi	Mec	29b. Signature and title of certifier John Source and address of person who co	mpleted cause of death (Item 23a) ((Type, Print)	0482	11/01	Month, Day, rear)
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UT U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3 2010 Physician/ 28 A^{M} Raymond Marshall Oct. 11:40 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 5550 Tuckerman Lane Room 415 North Bethesda Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 1 🔀 M 2 🗆 F Months Days Hours Min. Director 087-14-1551 Feb. Usual Residence of Decedent er than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No m MD North Bethesda Montgomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5550 Tuckerman Lane Room 415 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces? 9/24/42

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If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: 3 XWidowed 4 ☐ Divorced Completed Year or Dates. 2/12/46 White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) I R S <u>Attorney</u> and Mental Hygie is marked other permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ John Leo Tully Laura Mae Marshall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryann Shanesy / Daughter <u>609 Kent Oaks Way Gaithersburg, MD 20878</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 🔀 Burial 2 🗆 Cremation 3 🔀 Removal from State 4 Donation 5 Other (Specify) Jerome's Cemeterv 11/13/10 ome's Cemetery: 11/13/10 | Dorset, V7
22. Name and Address of Facility Joseph Gawler's Sons 21. Signature of Funeral Service Dicense William 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Debility Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Dysphagia Sequentially list conditions, if any, leading to immediate cate. Enter Underlying more than Due to (or as a consequence of) Exami and I-transit Late Effects Cerebral Vascular Accident 10 Years Cause (Disease or linjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? ☐ Pregnant at time of death☐ Unknown Yes 2 No the 9 Unknown signed by that be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Seizure Disorder, Chronic Lymphocytic Leukemia 1 ☐ Yes 2 🛂 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No page 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 💢 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State, Medical 29a. Certifier 👺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar (Check

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Susan J. Miller MD 8218 Wisconsin Ave. #305 Bethesda, MD 20814

To the within 2

10

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month. Day, Year)

28/2010

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D35579

29c. License number

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Nov.2, Physician/ Maria Vdovina 2010 <u>00</u>17 ^M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🏋 Hours 8 19 1 1 9 2 7 83 212-67-1982 Ukraine Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examinar must be notified at Completed by Funeral Director MD Montgomery Rockville 1 Kyes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6121 Montrose Road 20852 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Force Black. White, etc. 1 Yes 2 If Yes, Give Year or Dates. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: White 3 X Widowed 4 Divorced 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Chief of Fire Dept. Fire Dept. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Petr Zolotopup Ulyana Zolotopup and I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh tment of Health a tant: If item 27 i Nadezhda Gorokhova/daught. 11109 Flanagan Lane Germantown, Md. 20876 11/6弊/2010^{20c. Location - City or Town, State} 20b. Place of Disposition (Name of cemetery, crematory or other place)

Garden of Remembrance 20a. Method of Disposition permit. Page 1 Department of Important: If it any injury or o 1 🔀 Burial Clarksburg, Md. 4 Dong n 5 🗆 Other (Specie PHT电和PdDsR电MALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 21. Signature of Funeral Service I 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiorespiratory arrest Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Hypotension Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to for as a consequence of Ischemia left foot attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical DOITAN Hospital or Attending Physician; The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No Day Year Month Pregnant at time of death 5 Other (specify) signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director; After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed?
Yes 2 No 25. Was case referred to medical Division of Vital VADVINA 26. Place of Death (Check only one) Be examiner? Hospital: Other: ပ္ 1 ☐ Yes 2 🔀 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27, Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending iniury work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year, Nov.3,2010 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nadar Shanthi MD. 8701 Old Georgetown Road Bethesda, Md 20817 Month, Day, Year) NOV 05 2010 31. Date filed 3. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

10-08479 Anne Vossler

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 36638 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Month Day November 6, 2010 **Medical Examiner** 0215 hrs ANNE CHRISTINE BERARD VOSSLER 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 8510 Greenwood Avenue Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24Hrs. 8, Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Davs Director Hours 216-64-6691 57 08/19/1953 2 XF 1 M Yrs Usual Residence of Decedent any 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show 1 XYes 2 No items 23a or 28a-f shorust be notified at once. Takoma Park Montgomery with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8510 Greenwood Avenue, #1A 20912 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married 1 Yes 2 No 9 3 X Widowed 4 Divorced If Yes, Give Year White Pages 1 and 2 should be filed within 72 hours after pent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner. 1 Yes 2 X No specify: Specify: ģ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Self Employed Artist 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be A. Edward Victor Berard Catherine McBrien ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jessica Vossler - granddaughter 3620 Marquerite Court, Mt. Airy, MD 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State crematory or other place) permit. Pages
Department of
Important: I Donation 5 Other Specify Cremation Svc 11/10/10 Hanover, MD 21. Signature of Funeral Service Nice 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part I. Enter the disease, or comp Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on e Between Onset and /Medical Atheroscleretic cardiovascular disease Death Immediate Cause (Final disease Ixaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last signed by the attending physician and be detached for use as the burial - transi The law requires that the death certificate be executed Physician/Medical XUNPENDED AMENDED 23a, 27, per ME g910 12/8/10 TT Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 V Unknown Completed icate has been si page 2 should b 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes To the Hospital or Attending Physician: Division of Vital 25. Was case referred to medica filled in by the funeral director, 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 Other₄ ER/Outpatient 3 DOA this Nursing Home 5 Residence 6 Other: Scene ဥ 1 🗸 Yes After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural death. hours after death. 1 Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 🔲 Suicide Could not be or Town, State) within 24 hours a To the Funeral I determined Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 255. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E November 6, 2010 30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medigal Examiner 111 Penn Street, Baltimore, MD 21201 Registrar's Signature State Registra

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OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Wyvill October 27, 2010 George John 8:50P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince George Prince George's Hospital Cheverly Social Security Number 7. Age (In yrs, last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days 1 X M 2 □ F Hours 82 7 / 237 19287 Washington, DC 215-20-2894 **Director** Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Maryland Prince George Upper Marlboro 1 - Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14719 Crescent Drive 20722 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. item 27 is marked other than "natural", or iten other traumatic event, the Medical Examiner 1 X Yes 2 No Korean If Yes, Give War Black, White, etc. Completed by permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important, If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinance ones. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3XXWidowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Self-Employed Liquor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ George Α. Wyvill Beatrice Wells 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debbie Curry/Daughter 15424 Mt. Calvert Rd. Upper Marlboro, MD 20772 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Resurrection Cemetery 11/2/2010 Clinton, Maryland 5 Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 ales 23a. Par . Enter the disea e, or complicat ins that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cruse on each line. Immediate Cause (Final Onset and Death Physician/ elevation myocardial infarction disease or condition Medical resulting in death) 1 mth Examiner Bacteremia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit ailure nth Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown in the past 12 months?
1 ☐ Yes 2 ☐ No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Congestive heart pailure Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred 1-Natural injury 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

BAIVA Registrar

DHMH 17 Rev 7/2009

3001 HUSPITAI Drive

wan

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
The Ima Ayensu, Mp 3001 Hospital

32. Registrar's Signature

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Division	or Attending fter death. irector: After in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of injury building, etc. (\$	- At home, farm, str Specify)	reet, factory, office		28f. Location (S City or Tow		or Rural Route Number,
_	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completely filled in by the fu		(check only 2 Medical Exami	sician: To the best of m	amination and/or in	h occurred at the ti	me, date and place	, and due to the arred at the time,	cause(s) and manne date and place, and	er as stated. If due to the cause(s)
	the H thin 24 the Fi	Medical	one) 29b. Signature and title of certifier	and manner stated		29c. Licens			29d. Date signed (N	
	6 월 년 S	-	Do A			21	25- A	00	· lovious	20117010
			30. Name and address of person who c	ompleted cause of dea	th (Item 23a) (Type	, Print)			MOYON II	0.700
	2		M. chael			>	600	North Wo	lfe St, Balti	more, MD, 21287
	Sta		31. Date filed (Month, Day, Year)	32. Rygistrar's	Signature	backer				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year 7:15A. Augustine Poff Walton November 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Independence Court Assisted Living Hyattsville Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Aug. 15, 1 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Days 1 □ M 2 🕅 F 87 1923 Virginia 229-24-6075 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Maryland Montgomery Silver Spring 1 ☐ Yes 2 No 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 3141 Beethoven Way 20904 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ▼No þ Specify: 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Housewife own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William F. Poff Hoover Jane King ပ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3141 Beethoven Way Silver Spring, Maryland 20904 Paul Bryant Walton -son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 11/6/2010 Restvale Cemetery Copper Hill, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Donald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dementia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy 24 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother Assisted Livin Hospital: 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred

Examiner requires that the death certificate be executed burial-trar Division or Vital Records, P.O. Box 68760, physician the as attending use ρ ed by the a signed b peen page 2 certificate ! this funeral (ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director; After t After t the filled in by

Physician

/Medical

Examiner

Funeral

Director

28a-f show

with

72 hours after death

filed within

Baltimore, Maryland 21215-0036

Director

Funeral

Be

Examiner

r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at

marked other

peprilt. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumatic event.

Physician /Medical

> Physician/Medical þ Completed Be P Certification:

5 Pending investigation 6 Could not be

3 Suicide 4 Homicide 29a. Certifier

2 Accident

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certifie

29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ivan Zama, M.D. 9200 Basil Ct., #200 Largo, Maryland 20774

State Registrar

Medical

31. Date filed (Month, Day, Year) NOV 05 2010



within 24

To the I

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 7. Allen Wood L. 2010 10:00 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Charlotte Hall Veterans Home Charlotte Hall St. Mary's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Ohio (Ohio 278-36-5033 Feb. 13, Year 1939 71 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 🗌 Yes 2 ื No Maryland Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12107 Piscataway Road 20735 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 X Married X Yes 2 No Baltimore, Maryland 21215-0036 1956 1 Yes 2 No Specify: If Yes, Give Specify: White 3 Divorced 4 Divorced Year or Dates 60 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Linesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Wood Virginia Α. Ryan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dale Wood - Wife 12107 Piscataway Rd., Clinton, MD 20735 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other placel 1 Durial 2 K Cremation 3 Removal from State 4 Donation 5 Other (Specify) Kalas Crematory 11/9/2010 Edgewater, MD 21. Signature of Funeral Service License 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. CAK 6160 Oxon Hill Rd., Oxon Hill, MD 20745 Fart. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ IME ZHB) Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DEPRESSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? After this certificate 2 No 2 No Yes To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Yes 2 NO 4 Nursing Home 5 Residence 6 Other Specify 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Contifying Nurse Prentioner: To the best of my knowledg 29b. Signature and title of cartifier 29d. Date signed (Month, Day, Year) MD 11.8-2010 D0067788 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CR 5+1

DHMH 17 Rev 7/2009

Registrar

LEENA

31. Date filed (Month, Day, Year) NOV 0 9 2010

RAO

KODALT

14090 HG Trueman Rd., Suite 2300, Solomons, MD 20678

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2

				epartment of Health and I Ce <i>rtificate of Death</i>		71111	36643
	Physicia	ın/	1. Decedent's Name (First, Middle, Last) Sherwin W. L. Winter	Joi imouto or Doutin	2. Date of Dea		3. Time of Death
· · · ·	Medic Examin	cal	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	1.	4c. County of Dea	
	<i>?</i>		Holy Cross Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birtho		ID	Montgomer	-
	Funeral Director		577-80-6563 1x□ M 2 □ F 63 Yı	rs. Months Days Hours Min.	8. Date of Birth (Month Day 11-20-1	1946 Guy	thplace (State or Foreign untry) ana
	show d at	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of the county				10d. Inside City Limits
	r 28a-f notifie	Director	MD Montgomery Silver	Spring 10f. Zip Code		10g. Citizen of What Co	1x Yes 2 □ No
	with the second	Funeral	8811 Colesville RD	20904		United Stat	-
9	or iterr miner n	by Fu	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ ▼ No	 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
-003	ours aft atural", sal Exa	eted I	3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 √ No Specify:			ican American
1215	hin 72 h ne. than "n e Medi	Completed	(Specify only highest grade completed) ((Elementary/Seconday (0-12) College (1-4 or 5+)	recedents obtail Occupation Give kind of work done during most of work fe. DO NOT use retired) entist	king	16b. Kind of Business Self Employ	*
1d 2	iled with Il Hygien other i	Be	17. Father's Name (First, Middle, Last)		ne (First, Middle, I	Maiden Surname)	
rylar	uld be t d Menta marked natic e	2	Edward Winter		a Mattis		
, Ma	nd 2 sho salth an n 27 is er traur	- 5	L. L. L. L. L. L. L. L. L. L. L. L. L. L	Mailing Address <i>(Street and Number or Rur</i> 12 23rd Parkway Tem			o Code)
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1	Disposition (Name of crematory or other place) Ston National 11–1	Date 0-2010	20c. Location - City or Suitland M	
3altir	permit. P Departme Importar any injur		21. Sign fun of Funeral State Licensee	7 22. Name and Address of Facility John T. Rhines F.H	110 30		
	σΩ = α οι		23a Part 1. Epier the disease, or complications that caused the death. Do not	<u> </u>	Wa	ishington,D	C 20017 Approximate
- 1	Trysician,	i q	shock, or heart failure. List only one cause on each line. In mediate Cause (Final diease or condition resulting in death) Metastatic Col.	on Cancer			Interval Between Onset and Death
	Medical Examiner		Due to (or as a consequence of)	:			
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury				
	cate be executed physician and the burial-transit		that initiated events cresulting in death) Last C. Due to (or as a consequence of)	:			
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Box 68760	ath certii attending for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Live Birth 2 □ Fetal death 1 □ Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of de	livery Day Year
Э	the des by the s	hysic	9 Unknown				
Division of Vital Records, P.O.	ires that signed d be de	ρ	Part II. Other significant conditions contributing to death but not resulting in the Gastrointestinal Bleed	he underlying cause given in Part I.		bacco use contribute to ′es 2 □ No 3 □ P	the cause of death?
cord	aw requ as been 2 shoul	Completed	Severe Malnutrition		24a. Was a		topsy findings available completion of cause of
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Vita	hysicia nis certi I directe	To Be	examiner? 1	26. Place of Death (Checonation 3 DOA Other:		ence 6 Other (Spec	ify)
on of	nding P ath. :: After tl e funera	cate:	27. Manner of Death 1 🔀 Natural 5 🗌 Pending 2 🗋 Accident Investigation		28d. Describe ho	ow injury occurred	
ivisio	or Atter after des Director in by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homlcide determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (St City or Town	treet and Number or Ru n, State)	ral Route Number,
Δ	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or in	ath occured at the time, date and place, a	nd due to the cau	se(s) and manner as sta	ated.
	fo the H vithin 24 fo the F complete		only one) 3 Certifying Nurse Practioner: To the best of my knowled 29b. Signature and title of certifier	dge, death occurred at the time, date and plant 29c. License number	ce, and due to the	cause(s) and manner as 29d. Date signed (Monti	stated.
) Sol IR	D0064100		11-4-10	
2	3		30. Name and address of person who completed cause of death (Item 23a) (Тур Smitha Bhikkaji	po, 1 11119		Glen Road g MD. 2091	0
	Stat Registra		31. Date filed (Month, Day, Year) NOV 0 9 2010 32. Registrate Signature				

			For State	of Maryland / De			Mental Hy	giene	10	36644	
			Registrar 1. Decedent's Name (First, Middle, Last)	ertificate of L	Jeath		2. Date of Death 3. Time of Death				
Physician/			Yakov D		Month Nove			2010	1:30p M		
Medical Examiner			4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of D			r Location of Deat					
			Holy Cross Hospit 5. Social Security Number 6. Sex	al		ver Spri				iomery	
Fune Direc			5. Social Security Number 216-45-4828 6. Sex 1 ☑ M 2 ☐ F		Months Days	If Under 24 Hrs Hours Min		h /, Year) /1 0 2 0	9. Birth	place (State or Foreign htry) Ukraine	
			Usual Residence of Decedent	80 Yrs			01/1//	1930		ueuche	
yland f sho		ķ	10a. State 10b. County	10c. City, Town or	Location				1	10d. Inside City Limits	
e Mar r 28a		Director	Maryland Montgomery 10e. Street and Number		10f. Zip Code	ilver Sp	ring	10 000		1 Yes 2 No	
vith th		al	11975 Andrew Street		Tot. Zip Code	20902		10g. Citizen of	U.S		
eath v tems		Funeral	11. Marital Status 12. Was Dec	cedent Ever in U.S. 1	3. Was Decedent of H	ispanic Origin? (S	pecify Yes or No-	14. Ra	ce - Americ		
sifter d		ਨ	If Von G	3 2 🗓 No	If Yes, specify Cuba		to Hican, etc.)	Bla Specif	ack, White,		
-UUSO ours after atural", o		Completed	3 Widowed 4 Divorced Year or 1	Dates.	cedent's Usual Occup					White	
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and he filec ntal H ed otl		To Be	17. Father's Name (First, Middle, Last)	,		18. Mother's Na	me (First, Middle,				
ould b mark mark			Pavid Zengin 19a. Informant's Name/Relationship (Type, Print)			Horess (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
Mic d 2 sh alth ar c 27 is		1	Marina Burtseva - Daug	1.4	75 Andrew					· ·	
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Datimo			4 Donation 5 Other (Specify)	III State	n Memorial	Pk. 11/	04/2010	Rockvi	lle,	Maryland	
Dariffilore, IMaryliating ZIZI3-UU30 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f show any initury or other traumatic event, the Medical Examiner must be notified at	ouce.		21. Signature of Fundiral Service Licens	11711						Home, Inc.	
_			23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate							Approximate	
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lospit 4 hour unera		Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							d.	
To the Hospital or Attending Physical Within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral director.			only one) 3 L Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place			ace, and due to the	, and due to the cause(s) and manner as stated.				
7	3		Barbara Aupania		29c. License number			29d. Date signed (Month, Day, Year) [11 103 1 3016			
		-	30. Name and address of person who completed cau	use of death (Item 23a) (Type	em 23a) (Type, Print)						
			Barbara Supanich, RSM,	MD. 1500 For	iest Glen 1	Road, Si	lver Spr	ing, Ma	rylan	ed 20910	
Regi:	State stra	-	81. Date filed (Month; Day, Year) NOV 05 2010	Registrar's Signature	will						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death A 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ ovemb Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner more 9: Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In **Funeral** 1 🕱 M 2 🗆 F Months Hours Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified anone. 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 XYes 2 No more 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Apt Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 ☑ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 19a. Informant's Name/Relationship (Type, Print) (doughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 20 4 ☐ Donation 5 ☐ Other (Specify) 21. Sonature of Funeral Service Licenses Joseph L. Russ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Massale Onset and Death 3m (07) Immediate Cause (Final and mer Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to lor as a consumence of cause. Enter Underlying attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant Pregnant at time of death s been signed by the s Unknown Part II. Other significant conditions contributing to death but/hot resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an - has the funeral director, page 2 autopsy performed 2 NO 24 hours after death.

Funeral Director: After this certificate 1 🗌 Yes 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be Hospital Other: ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ 1 Inpatient 2 27. Man r of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? Natural 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the F only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and -22-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MALIKA JASEAM . 709 CAST ERN BLVD 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month I homas, 1400 2010 Medical Nov 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death of Maryland Medical Center Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign C Months Days Hours Min Director brichile, Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD 1 X Yes 2 No 10e. Street and Number ö 10g. Citizen of What Country? Funeral 23a Avenue 1460 items 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 X Married 72 hours after ō þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exa any injury or other traumatic event, the Medical Exa gonee. 1 ☐ Yes 2 🗹 No Specify: 3 Divorced Completed White Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) McCormick and Elementary/Seconday (0-12) College (1-4 or 5+) 2 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Artes Adams amia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Avenue <u>Ihomson</u> MD 21201 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) to sest Hill. Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Papel and Cremation Services
Evans Furerou chapel and Cremation Services
8800 Harford Road Parkuille Manyland Parkuille Manuand 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Septic Shock secondary disease or condition WRPKS Medical resulting in death) Due to (as a consequence of): Examiner colitis aweeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that Initiated events Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Crohn's dispase. 2 weeks and -tran Due to (or as a consequence of) resulting in death) Last the burial ate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death Month Vear Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eral Director: After this certificate has filled in by the funeral director name? performed Yes 2 N 1 Tes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital: 2 **N**o 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Nov., 19,2010

within 24 hours a Medical Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifier 1841425592 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 South Greene Street, Baltimore, MD Danie 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 1-2016 Maryans Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Baltimore **Gilchrist** Towson 5. Social Security Number 1 Year If Under 24 Hrs. If Under 8. Date of Birth (Month, Day, Mar • 23 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year 1922 Country) Maryland 1 □ M 2 😿 F Months Days Hours Min. 88 215-16-9316 Yrs Mar. Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County iral", or items 23a or 28a-f shorexaminer must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Marvland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 507 McManus Way 21286 U.S.A. death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 🔀 No Specify: "natural", Completed 3 Widowed 4 Divorced Specify: White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 10 years Homemaker Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental h Important: If item 27 is marked any injury or other 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ပ္ Siatkowski Adam Karolina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce A. Lester (daughter) 507 McManus Way Towson, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State Stanislaus Cemetery 11-24-10 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home Inc.
6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ometri Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) the burial physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ Month Year Pregnant at time of death Day s been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has autopsy performed? Yes 2 K No page 1 🗌 Yes 2 🗌 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 2 No Other: 1 🔲 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1- Natural 5 Pending injury s after death. 1 ☐ Yes 2 ☐ No. Accident Investigation the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, completed filled in by determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Scertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

DHMH 17 Rev 7/2009

Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Chan

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 2010 05: 05 PM hristine NOVEMBER 19 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins BALTIMORE Boyview Med Ctr 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Months Hours 1 □ M 2 🗹 F Days 52 218-74-7803 Director October 10,1958 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show d other than "natural", or items 23a or 28a-f show event, the Medical Evandrier must be notified at BALTIMORE - DUNDALK Director 1 □Yes 2 □XNo Baltimore MD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 212 Robwood death v Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian filed within 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. 2 Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) 12 years Pharmacy Tech Drug Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joe Palarmo Sr. Anna Kultz other traumatic ం 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau Bernardino Adolfo HUsband 210 Robwood Road, Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 November 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Bayview Crematory 24, 2010 4 Donation 5 Dother (Specify) 21. Signalure of Funetal Service Licensee ² Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Multi-system Physician 1 days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of requires that the death certificate be executed burial-trans and Due to (or as a consequence of) Box 68760 attending physician Physician/Medical the as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 5 Other (specify) P.O. the 9 Unknown 9 Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed certificate 2 No 2 No Division of Vital 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ္မ 1 MInpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 ☑ Natural 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 5 Pending 1 24 hours after death. le Funeral Director; A bletely filled in by the fu 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Lecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0

State Registrar

DHMH 17 Rev 1/2001

Eastern

4940

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KHW

ANTHONY N
31. Date filed (Month, Day, Year)

23 2010

M.D

32. Registrar's Signature

Back

NOVEMBER 19,2010

Avenue Baltimore MD 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year 2010 Month ettu Authenreath 1:30 AM November Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Medical HOOKINS Bauriew altimore Center N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Dec. 21, 1937 Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 M 2 X Months Director 226-48-5792 Yrs. Virginia Usual Residence of Decedent show e 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. Count Director 10c. City, Town or Location 10d. Inside City Limits **Dundalk** Baltimore 1 ☐ Yes **②XX**No MD 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21222 1613 Four George's Court United States Apt. A2 Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes ②XX No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4XX Divorced Specify. Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working Johns Hopkins Elementary/Seconday (0-12) College (1-4 or 5+) Health Care Provider 12 Years 4 Years Registered Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Hattie H. Harrison John T. Hale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 Broad Leaf Court Rising Sun, MD 21911 James Authenreath (Son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 Department of Important, If it any injury or o 1 Burial 2 X Cremation 3 Removal from State 11/20/2010 Towson, Maryland Hilltop Service Corp 4 Donation 5 Other (Specify) Duda-Ruck Funeral Home of Dundalk, 7922 Wise <u>Ave</u>. <u>Dundalk</u>, Maryland 21. Signature of Funeral Service Licenses art 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ oke disease or condition resulting in death) 045 Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence or). the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 🗷 No Pregnant at time of death Month Day Year 1 Yes 2 2 9 Unknown s been signed by the system of should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 s performe death? Director, After this certificate I ☐ Yes 2 🗙 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 🗷 No Other: မ 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work? 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 006 9625

Registrar DHMH 17 Rev 7/2009

State

Avenue

Eastern

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 49

Liona

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NoV. 20^{Day} 2010 ar 5:30 P Gwendoline L. Ayres Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Maples of Towson Baltimore Towson Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🕱 F Months Days Hours Min Oct. 17 84 Yrs. Maryland **Director** 217-24-9156 926 Usual Residence of Decedent show 10a. State 10b. County within 72 hours after death with the Maryland aţ Director 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f s edical Examiner must be notified Lutherville Md. Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1825 Notre Dame Ave. 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🗓 No Specify: Completed 3 XWidowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other tha ury or other traumatic event, the N Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 Dora Clark Ratcliffe Ed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10807 Lakespring Way Cockeysville, Md. 21030 <u>Sharon Harrison/ Daughter</u> Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mays Chapel Cemetery 11-24-10 Timonium, Md. Signature of F Meral Servi ^{22. Name and Address of Facility}
Ruck Towson Funeral Home,
1050 York Rd. Towson, Md. Licen 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Disease or injury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year 9 Unknowh Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed? Yes 2 1/No 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital 2 No 욘 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural injury 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) ☐ Homicide determined 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

Division of Vital Records, P.O. Box 68760 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEUZ 2 3 Registrar DHMH 17 Rev 7/2009 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ John Edward Burton, Sr. Month November 2010 16 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Balto. 4110 Pinedale Drive Nottingham Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Yea 9. Birthplace (State or Foreign Country)
5 Maryland **Funeral** 1 X M 2 □ F Months Days Hours Director 220-18-2976 December Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director Balto. 1 Yes 2 X No Md. Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4110 Pinedale Drive USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Western Electric Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Robert Burton Eva Strickland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty J. Burton Spouse 4110 Pinedale Drive Nottingham, Md. 21236 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 № Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Holly Hills 11-20-2010 Middle River, Md. 21. Signature of Funeral Service Licenses lame and Address of Facility Schimunek Funeral Home 9705 Belair Road Nottingham, Md. 21236 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ Endstrat disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner nce of) Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed MSI attending physician and for use as the burial-trar as a consequence of Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year the 1 ☐ Yes 2 ☐ 9 ☐ Unknown sate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? [조 Completed 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 Yes 2 No __ Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home **₽** No ျှ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 6 Could not be ☐ Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State Medical 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Belair Rd Baltimore MD 2123L atricia 9524 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Vear DM Rosa Bell Brunson Medical Vovember 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death OF Baltimore 6. Sex (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 □ M 2 🛛 F Months Days Hours Min. 127257 1949 S. Carolina **Director** 60 218-76-7156 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD N/A Baltimore 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be I Funeral 3842 Boarman Ave. 21215 U.S.A. 12. Was Decedent Ever in U.S. 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Xever Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced Specify: Black Brunson, Rosabell 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Elementary/Seconday (0-12) unk life. DO NOT use retired) College (1-4 or 5+) N/A N/A1 and 2 should be filed wit f Health and Mental Hygie item 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Willie Moses McFadden Willmenia Unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Lucille Tyler(aunt)</u> 3713 <u>Hillsdale Rd., Baltimore, MD 21207</u> 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of F Important: If ite 20c. Location - City or Town, State Date Josephre Browner & And Crematory 1 Burial 2 Fremation 3 Removal from State 231 4 Donation 5 Other (Specify) Baltimore, MD Signature of Funeral Service Licensee Address of Facility h Hulton 2440eph wave::Baltimore:MDe2P217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if my Lewing Land cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last prepra Due to (or as a consequence of attending physiciar Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregna 5 ☐ Other (specify) Pregnant at time of death the s 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform this certificate 1 Yes 2 No Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? ٥ 1 🗌 Yes 2 X No 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at After 28d. Describe how injury occurred 1 X Natural 5 Pending 2 🗆 No Accident Investigation 24 hours after death Funeral Director: completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

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31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Baltimore 2401 West Belvedere Ave Baltimory 40

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 15, Margaret Mary Bauer 20°10 12:35 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth 93 1 □ M 2 XX Days Hours Min. Oct. 21 Director 212-05-1055 Maryland 1917Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore Parkville 1 ☐ Yes 2 X No 10e. Street and Number ò 10f. Zip Code Examiner must be 10g. Citizen of What Country? 23a Funeral 8810 Walther Blvd Apt 3119 21204 USA items 2 within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XXNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
 □ Yes 2 No Specify: 11. Marital Status 14. Race - American Indian, Black, White, etc. P. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates "natural" Completed 3 XXVidowed 4 Divorced and Mental Hygiene.
is marked other than "natural aumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Draftsperson C & P Telephone it. Page 1 and 2 should be filed wi intment of Health and Mental Hygie ortant: If item 27 is marked other njury or other traumatic event, t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 은 Michael Voge1 Barbara Gross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Bauer (Son) 8111 Pleasant Valley Rd Stewartstown, PA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Department of H Important: If ite any injury or ot 20c. Location - City or Town, State 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 11/19/10 Baltimore, MD of Funeral Service 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd, Nottingham, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final nset and Death Physician/ DEMENTI disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of). attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Unknown Month Day Year signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HCART FAILURO ONGOSTIVE Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed certificate Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: ျပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Sp After this 27. Manner of Peath Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation Could not be 24 hours after deat Funeral Director: Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie

State Registrar DHMH 17 Rev 7/2009 nd address of person who com

31. Date filed (Mo.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2350M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Oak Crest Care Center Parkville Baltimore Social Security Number 6. Sex 7. Age (In yrs. last birthday) 83 yrs If Under 1 Year If Under 24 Hrs. Date of Birtii (Month, Day, Year) 10 1927 **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 216-20-4634 1 □ M 2 🛛 F Months Days Hours Min. Baltimore,MD Director Usual Residence of Decedent 28a-f show 10b. County ms 23a or 28a-f sho must be notified at 10a. State with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Parkville MD 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8800 Walther Blvd. 21234 U.S.A. items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. the Medical Examiner 14. Race - American Indian, Armed Forces ō Black, White, etc \$ 1 Never Married 2 X Married Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", 3 🗌 Widowed 4 🗆 Divorced If Yes, Give White Completed Specify: Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry should be filed within 72 hand Mental Hygiene. (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) At Home Housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maria Tamburini Frank Tampieri permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Herbert Becker/ Husband 8800 Walther Blvd. #2601, Parkville, MD 2 1234 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) vans Funeral hapel – Bel Air 1 Burial 2 X Cremation 3 Removal from State Forest Hill, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral 8800 Harford Chapel & Rd. Parkvi Cremation Lie. MD 2 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ 0 disease or condition returning in death) e or condition Medical Due to (as a construence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) that the death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? for Other (specify) Pregnant at time of death Month Day Year signed by the a d be detached f g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Hospital or Attending Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s has autopsy certificate performed 2 No 1 Tes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? 2 1 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes 2 🗆 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a, Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying furse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one 29b. Signature and title of certif e number 29d. Date signed (Month, Day, Year) rson who completed cause of death (Item 23a) 00 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36655 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JOSEPH Month BON HO 77 0 700 A.M Medical oveml 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital Baltimore 5. Social Security Number 6. Sex 1 M 2 D F If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Hours (Month, Day, Year) ec. 5, 1932 216-28-5424 Director 77 Yrs Baltimore. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner miss harmatic and once. 10a. State 10b County Director 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Baltimore 1 Yes 2 X No 10e Street and Number 10g. Citizen of What Country? Funeral 2800 Glavin Way Court Apt. 21234 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No If Yes, Give Year or Dates. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: 3 Widowed 4 X Divorced Completed White I 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore City Police Officer 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 George John Bonhoff Christine Rose Bilz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Bonhoff, Jr./ Son 501 Millwood Drive, Fallston, MD 21047 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Evans Funeral 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, MD Chapel Bel Air 22. Name and Address of Facility Evans Funeral Chap 8800 Harford Road, Chapel & Cremation Road, Parkville, MD 23a. Part I. Enter tile disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ SC disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or impury that initiated events Examine Due to (or as a consequence of) the burial-transi Due to (or as a consequence of): resulting in death) Last signed by the attending physician d be detached for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months? Month Pregnant at time of death Dav Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s After this certificate performe 1 Yes 2 No Yes 2 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? ည 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Could not be 24 hours after death Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 0018230 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Good Samartan Hospital, MD21239

Registrar DHMH 17 Rev 7/2009

State

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31. Date filed (Month, Day, Year) NOV 2 3 2010

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			Registrar 1. Decedent's Name (First, Middle, Last)	Certificate o	f Death		Reg. No 201	0 36656		
Physician/ Cathorine Marie Bonnett							2. Date of De Month	Day Yea	h A	
Medical Examiner 4a. Facility Name (if not institution, give street and number)					4b. City, Town	n, or Location of	Novembe of Death	21, 2010 4c, County of D	5:00 A M	
-			9205 Nottingwood Road		Rosed			Baltin		
Ī	Funeral		5. Social Security Number 6. Sex 7. A 1 ☐ M 2 🔯 F	ge (In yrs. last birthda 86 yrs	Months Day			th 9.	Birthplace (State or Foreign Country)	
-	Director		Usual Residence of Decedent	OO Yrs	S.		August		bryland	
	land shov dat	ţ	10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits	
	Mary 28a-1 otifie	irec	Maryland Baltimore	Rosedale	2				1 ☐ Yes 2 🔀 No	
	th the 3a or t be n	<u>=</u>	10e. Street and Number		10f. Zip Cod			10g. Citizen of What	Country?	
	ath wi	Funeral Director	9205 Nottingwood Road 11. Marital Status 12. Was Decedent	Ever In LLC 1	21237			United Sta		
9	er de: or ite	y F	1 Never Married 2 Married 1 Yes 2	?	If Yes, specify Co	uban, Mexican	gin? (Specify Yes or No- , Puerto Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.	
003	urs aff ural", Il Exa	ted	3 ☑ Widowed 4 □ Divorced If Yes, Give Year or Dates.		1 ☐ Yes 2 🔀	No Specify:		Specify: W	hite	
15-(72 ho "nat ledica	Completed by	15. Decedent's Education (Specify only highest grade completed)	(Gi	cedent's Usual Occive kind of work dor	ne durina most	of working	16b. Kind of Busine	ss Industry	
12	rithin iene.	Con	Elementary/Seconday (0-12) College (1-4 or	3+)	. DO NOT use retire	ed)		At Home		
br	illed wall Hyg	Be	17. Father's Name (First, Middle, Last)		usewile.	18. Mothe	er's Name (First, Middle,			
ylar	ld be i Menta arked atic e	ပ	Joseph J. Werneke				garet Cole	,		
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type, Print)				r or Rural Route Numbe			
	Heali tem 2		Joseph R. Webster (Son-in-law) 20a. Method of Disposition		sposition (Name of	II ROBO	White Hall, M			
Baltimore,	Page 1 Tent of Int: If i		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	e cemetery, d	rematory or other p		bv. 22, 2010	20c. Location - City Pel Air. Mar		
Salti	permit. Departri Importa any inju		21. Signature of Funeral Service Licensee			i	apel & Cremat	•	-	
	₫ □ = = 		Mary Call		88UU Har	TOYO KOO	o Parkville.	Marviand 212	-гагкулце 34	
			23a. Part 1. Enter the disease or complications that cause shock, or heart failure. List only one cause on each lin Immediate Cause (Final	ie.			- v		Approximate Interval Betw	
	hysician/ Medical		disease or condition	a consequence of):	errom	a of	Stoma	the	Onset and With	
	Examiner			a consequence oi).		/				
	, ±	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	a consequence of):						
	and trans	хап	that initiated events c	a consequence of):		_				
0	cate be executed physician and s the burial-transit	calE	resulting in death) Last	a consequence oi):						
2092	icate g phys		d							
89	onding use a	an/N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome	of pregnancy 2 Fetal death				23d. Date of d	deliverv	
Box 687	death he ath	Physician/M	in the past 12 months? 1 ☐ Yes 2 No 4 ☐ Pregnant a 9 ☐ Unknown 9 ☐ Unknown	at time of death 5	Other (specify)			Month	Day Year	
P.O.	requires that the death certific been signed by the attending should be detached for use as	Ph	Part II. Other significant conditions contributing to death b		e underlying cause	given in Part I	220 Did to	hassa usa santributa	to the cause of death?	
S,	ires the signer of the contract of the contrac	d by	Brancho alveola	- lino	canre	_		,	Probably 4 Unknown	
ord	v requ	Completed	atheroschrotte	(monda	ne Vol	Tulpa	U. Cen 12 24a. Was a		autopsy findings available	
3ec	The law cate has page 2 s	mo		00 80 1000	1	cherry	autop	rmed? prior to death:	completion of cause of	
la	sician: The certificate rector, pag		25. Was case referred to medical examiner?		26.	Place of Death	1 \(\text{Yes}\)	2 ☑ No 1 □ Y	es 2 No	
₹	Physic this ce	욘	1 Yes 2 No Hospital: 1 Inpati	ient 2 ER/Outpat	ient 3 🗆 DOA	ther: 4 🏻 Nun	sing Home 5 Resid	ence 6 🗆 Other (Spe	ecify)	
Division of Vital Records,	ding F h. After i funera	Certificate:	27. Manner of Death 1 Natural 5 Pending (Month, Da	ury 28b. Time y, Year) injury	wo	ork?	ı	ow injury occurred		
Sio	Atten	Ĕ	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury	ury - At home, farm, s		Yes 2 1		treet and Number or F	Pural Pouto Number	
Σ.	rs afte		building, etc	c. (Specify)	, ,,	reer, factory, office 28f. Location (Street and Number or Rural Rout City or Town, State)				
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of e	examination and/or inv	estidation. In my onir	nion death acc	urred at the time date ar	nd place and due to the	a aquipa(a) and manner stated	
	To the within To the compli		only one) 3 Certifying Nurse Practioner: To the 29b. Signature and title of certifier	best of my knowledge	e, death occurred at	the time, date a	and place, and due to the	cause(s) and manner a	s stated.	
			> Brokend 1. 2	lyht/1	0 04	1556	8	11/22/11	2	
			30. Name and address of person who completed cause of d	U ATA		3 /		1 - 1	- /	
	State		BRAD EBRIGHT %2 31. Date filed (Month, Day, Year) 32. Registra	4 Sele ar's Signature	in fo	d	DHCT, M	D 515	36	
П	Registra	=	NOV 2.3 2010 A	& knd).					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Avghi Benedict 2010 2010 November 6:25 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Oak Crest Care Center Parkville 5. Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2X F Days Hours 126-26-2267 84 Director Yrs December 8 1925 Cyprus Usual Residence of Decedent or 28a-f shov notified at show 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore Parkville 1 Yes 2 No 10e, Street and Number ō 10f. Zip Code ortant if item 27 is marked other than "natural", or items 23a o injury or other traumatic event, the Medical Examiner must be 10g. Citizen of What Country?
United States Funeral 8810 Walther Blvd. Apt. 3401 21234 of America 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married 1 Yes 2 No If Yes, Give Year or Dates. Page 1 and 2 should be filed within 72 hours after Maryland 21215-0036 1 Yes 2 X No Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) f Health and Mental Hygiene. item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Evagoras Jacovides Ioanna Mitsis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21234 Nicholas P. Benedict/spouse 8810 Walther Blvd. Apt. 3401 Parkville, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral Chapel – Bel Air 20a. Method of Disposition Department of F Important: If ite 20c. Location - City or Town, State November 1 Burial 2XXCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 24, 2010 Forest Hill, Maryland 21. Signation of Marian Service Light See 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr., P.A
2325 York Road Timonium, Maryland 21093 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Onset and Death Deneuk disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year signed by the a d be detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ASCUD 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed Diabetes 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death? ate has bage 2 s performed' 2 No Yes 2 No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2/ No ပ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Could not be 24 hours after deat Funeral Director, Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death accounts at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5800 31. Date filed (Month, Day, Year) Registrar's Signature State 2010 Registrar NUA

10-08705

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 36658 State of Maryland / Department of Health and Mental Hygiene Tina Marie Brown 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ Month Medical Examiner Tina Marie Brown 1010 hrs November 13, 2010 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Harford Havre de Grace 1144 Chesapeake Drive If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 217-08-8725 25 Director Country) June 5, 1985 M 2XF Usual Residence of Decedent 10d. Inside City Limits ā 10b. County 10c. City, Town or Location Havre de Grace Harford County 1 Yes 2 No 28a-f show Maryland item 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21078 3707 Rock Run Road ۵ permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2 X No Yes 4 Divorced If Yes, Give Year White 3 Widowed 1 Yes 2XX No specify: Specify: Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Bulle Rock Waitress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thomas Edward Brown, Sr. Patricia Mae Wood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3707 Rock Run Road, Havre de Grace, Maryland 21078 Patricia Wood (Mother) If item 27 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) injury or other 1 Burial 2 Cremation 3 Removal from State 11/30/2010 Forest Hill, Maryland Evans Funeral Chapel Donation 5 Other Specify: 21. Signature of Funeral Service Licensee

22. Name and Address of Facility,
Evans Funeral Chapel & Cremation Services-BelAir
3 Newport Drive, Forest Hill, Maryland 21050

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart

Approximate Interval Physician Between Onset and failure. List only one cause on each line. /Medical Death Methadone and Oxycodone Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical AMENDED #23a, 27, 28a-f, perME, G910, 12/10/2010, WS attending physician for use as the burial -X UNPENDED Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 2 Fetal death Month Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 ✓ Unknown ۵. Completed 24b. Were autopsy findings available 24a. Was an pnor to completion of cause of autopsy page 2 s death? performed certificate ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) of Vital æ Other₄ Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 🗸 Other: Scene this After 28a. Date of Injury 28d. Describe how injury occurred subject ingested Methadone & 27. Manner of Death 28c. Injury at Work Pending 11/13/2010 Yes 2 X No To the Funeral Director: completely filled in by the 0930 hrs xycodone 2 X Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1144 Chesapeake Drive Havre de Grace, MD 21078 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be (Specify) other Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 14, 2010 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U For State Certificate of Death Decedent's Name (First Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1345 Campus Court Westminster Carroll Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 XF Hours 62 043-46-6123 Director Yrs CT Usual Residence of Decedent 28a-f shov filed within 72 hours after death with the Maryland 10a. State 10b. Counfy 10c. City, Town or Location 10d. Inside City Limits Director must be notified Glen Burnie MD Anne Arundel 1 Xes 2 No 6 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 27 is marked other than "natural", or items 23a traumatic event, the Medical Examiner must be Funeral 302 Blue Water Court # 203 21060 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Force Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2**X** No Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify. If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) 12 Secretary Service Ве 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surgame)
Grace E. Wildowsky 12 should be file tith and Mental H ပ Everett Haskell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Elizabeth A. Graham/Daughter 1345 Campus Court, Westminster, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Final", Journey "Crem. 11/25/2010 Woodbine, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility

Maryland Cr
PO BOX 1413 21. Signature of Funeral Service Licensee Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final disease or condition Onset and Death Ph sician/ Medical resulting in death) Due to (or as a **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day by the g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ě 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? certificate Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Z No Other: <u>ام</u> 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred Natural Director: After injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after of Funeral Direct filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number and address of person who completed cause of death (Item 23a) (Type, Print Lie 02 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 7/2009

				State of Marylan							Legible.	
		-	For State Registrar				of Death			Reg. No	010	36660
	Physicia Medic	n/	1. Decedent's Name (First, Middle, Las Albert Lee Bowers	t)				2	2. Date of Dea	ath 18	2010	3. Time of Death 8:00P M
	Examin	er	4a. Facility Name (if not institution, give street and number) 3303 Woodring Avenue				4b. City, Town, or Location of Death Baltimore				County of Death	
	Funeral Director		216-24-1/69	ex 7. Age (In yrs. la	ast birthday) Yrs.	If Under Months	1 Year If Under Days Hours	Min.	B. Date of Birt (Month, Dath 1	h <u>y, Year)</u> 5,193	9. Birth Cour Mar	nplace (State or Foreign ntry) cyland
	aryland ka-f show ified at	l. I	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimo		y, Town or Lo	cation Bal	timore C	ity				10d. Inside City Limits 1 X Yes 2 □ No
CR5	vith the M 23a or 28 st be not	Funeral Director	10e. Street and Number 3303 Woodring Ave			10f. Zip	Code 21234			_	zen of What Cou	intry?
15000 036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1XXYes 2 ☐ No If Yes, Give Year or Dates.			ent of Hispanic Or fy Cuban, Mexical	igin? (Speci n, Puerto Ri	fy Yes or No- can, etc.)	1	4. Race - Ameri Black, White, Specify: Whit	etc.
/ ナレじにらず ト. ンc Baltimore, Maryland 21215-0036	thin 72 hour sne. than "natu he Medical	Be Completed	15. Decedent's E (Specify only highest grant Elementary/Seconday (0-12)	ade completed) College (1-4 or 5+)	(Give life. D	dent's Usua kind of wor O NOT use		st of working		11	nd of Business Ir	
land 2	d be filed wi Aental Hygie Irked other Irc event, ti	To Be (10 yrs. 17. Father's Name (First, Middle, Last) Raymond E. Bowers	N/A	I ACC	.00116	18. Moth	,	First, Middle,	Maiden S	urname)	101
Mary Mary	d 2 should alth and N 27 is ma er trauma		19a. Informant's Name/Relationship (7) Charles L. Bowers			_	(Street and Numb					
/+ L じにらい	Page 1 an nent of He int: If iten iry or othe		20a. Method of Disposition XIX Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	Place of Dispo emetery, cren kwood	natory or o	her place)	Da			cation - City or i	
Balti	permit. Departn Importa any inju	3	21. Signature of Funeral Service Licens	als			Address of Facili	ity Las . Balt	sahn F timore	unera , Md.	al Home 21236	
	Ph __ sician/ Medical Examiner		23a. Part 1. Enter the disease, or com shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequ		er the mode	e of dying, such as	cardiac or I	respiratory an	rest,		Approximate Interval Between Onset and Death
W&		cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or influry that initiated events resulting in death) Last	b. Due to (or as a consequence) Due to (or as a consequence)								years
Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death. Within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnant Live Birth 2 Feta Feta Pregnant at time of 0	aldeath 3	☐ Ectopic p☐ Other (sp				2	23d. Date of deli	very Day Year
s, P.O.	res that th signed by d be detac		Part II. Other significant conditions of	-	sulting in the u	underlying o	ause given in Part	t I.				the cause of death?
Record	ne law requie has been age 2 shoul	Completed by	Anemia						24a. Was auto perfo	psy prmed?	prior to c death?	opsy findings available ompletion of cause of
Fal	ian: Ti ertificat ctor, pi	Be C	25. Was case referred to medical examiner?				26. Place of Dea	ath (Check o		2 2 140	7 2 103	2210
ξ	Physic this ce al dire	ျာ	1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatier			-			Other (Specia	fy)
ivision o	al or Attending Physis s after death. I Director: After this oed in by the funeral dire	Certificate:	27. Manner of Death 28a. Date of injury 28b. Time of injury at work? 28d. Describe how injury occurred 28d. Describe how injury							al Route Number,		
۵	ne Hospita n 24 hours ne Funeral pleted fillec	Medical	(Check 2 Medical Exam	sician: To the best of my know iner: On the basis of examination se Practioner: To the best of my	n and/or inves	stigation, in	my opinion, death o	occurred at the	ne time, date a	and place,	and due to the c	ause(s) and manner stated.
_	To the Comit		29b. Signature and title of certifier			290	. License number				e signed (Month	, Day, Year)
	140.		30. Name and address of person who	completed cause of death (Item	23a) (Type 1	Print)	D 31295			- //	19110	
	1000		wendy Kloesz	- mo 5701	Kenu	non	Ave T	300 in.	more	my	3 217	مي) ت
	Stat	re-	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie 1 1 - For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month 10:55a November 20, 2010 Steven Frank Brenner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Harford 8. Date of Birth (Month, Day, Year) Havre de Grace Harford Memorial Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 1 XM 2 ☐ F 1943 Yrs 67 Maryland 218-40-7597 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No Aberdeen Maryland Harford 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21001 USA 3509 Lark Dr. 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 GYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) servpro owner 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Rhoda Asner Phillip Brenner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3509 Lark Dr., Abordeen, MD 21001 Thelma J. Brenner (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State R.A.Ferris & Company 11/22/2010 West Chester, PA 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility} Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ptic Shock Se. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. path 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

23a or 28a-f ehow

or items

"naturel",

other then "

Pages 1 and 2 should be fill iment of Heelth and Mental H lant: If item 27 is marked other.

or other

permit. Page Depertment of Important: If eny injury or QDCB.

Baltimore, Maryland 21215-0036

the Medical Examiner must be notified at

Directo

Funeral

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Completed

12

sicien and burial-transit funeral director,

P.O.

Records,

Vital Physician:

of

or Attending

death.

Examine Be Completed by Physician/Medical 27 Manner of Death Certification: ф To the Hospital o within 24 hours eff To the Funcrel Di completely filled in

Medical

State

Registrar

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown End Stage 25. Was case referred to medical examiner?

1 Yes 2 No

1- Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

cardiomyo ertension

5 Pending

Revaral

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of investigation

6 ☐ Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State) t 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28d. Describe how injury occurred

24a. Was an autopsy performed? 1□ Yes 2,□No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

29b. Signature/and title of certifier Yyga 3. Nam, and address of person who comp -- cause of death (Item 23a) (Type -- III)

NION

29d. Date signed (Month, Day, Year) 2010 20.

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 24 No

31. Date filed (Month, Day, Year)

23 2010

32. Registrar's Signature park

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Ma	ryland / De	partment of I	Health and I	Mental H	ygien	е			
			State Registrar		C	Certificate of Death				Reg. Np. 0 0 3666			
	Physici	an/	1. Decedent's Name (First, Middle, Last)			n 1 1			2. Date of Death Month November 17, 201		3. Time of Death		
لا	Med → Exami		Stephen 4a. Facility Name (if not institution,	Jacob		udosh							
-	Zami	ner		give street and number)			r Location of Death		4	c. County of D			
S	Funera		Stella Maris 5. Social Security Number	6. Sex 7. Age	(In yrs. last birthda	Timo1	nlum If Under 24 Hrs.	8. Date of B	irth	Balti	.more Birthplace (State or Foreign		
	Director		077-10-9234	1 🕅 M 2 🗆 F	94 Yrs.	Months Days	Hours Min.	Dec 12	ay, Year)	15 Pe	Country) nnsylvania		
	ld now it	٦.	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or								
	arylar a-fsh fied a	100	,		*						10d. Inside City Limits		
M	he Ma or 28 e noti	ä	Maryland Baltin 10e. Street and Number	nore	Cato	nsville 10f. Zip Code		_	10 0	N. C	1 ☐ Yes 2 🔀 No		
D (with t	Funeral Director	1128 Pleasant V	Vallar Drive		212	20		10g. C	itizen of What	Country?		
:30	leath Items er mu	Ē	11. Marital Status	12. Was Decedent Eve	er in U.S. 13	B. Was Decedent of H		ecify Yes or No	-	USA 14. Race - A	merican Indian.		
2 98	fter of ", or i	þ	1 Never Married 2 Marri	Armed Forces? 1 X Yes 2 No. If Yes, Give	0	If Yes, specify Cuba 1 ☐ Yes 2 Xi No		Rican, etc.)		Black, W			
Ö	ours a rtural	ted	3 X Widowed 4 Divorced	Year or Dates.		ILI Yes 2 ALINO	Specify:			Specify:	White		
7.	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho , the Medical Examiner must be notified at	Completed	15. Decedent (Specify only highes	's Education t grade completed)	(Giv	edent's Usual Occup re kind of work done o DO NOT use retired)	durina most of work	ing		Kind of Busine	,		
2010 d 212	within giene. er tha the I	S	Elementary/Seconday (0-12) 12	College (1-4 or 5+) n/a		vil Engine				Army C gineers	orps of		
200	be filed yearlal Hyg ked oth	Be	17. Father's Name (First, Middle, La				18. Mother's Nam	e (First, Middle					
7, ylai	should be filed within 7: and Mental Hygiene. is marked other than aumatic event, the Me	욘	John	Bud	losh		Veroni	ca		Pite1			
₹ 7 Man	2 should th and M 27 is mar traumat		19a. Informant's Name/Relationshi	(Type, Print)	19b. Ma	iling Address (Street a	and Number or Rura	al Route Numbe	er, City o	r Town, State,	Zip Code)		
BEH e, N	and 2 s Health tem 27		Stephen J. Budo	sh/Son		Horncrest	Road, T	owson,	Mary	1and	21204		
NOVENBER	Page 1 anent of Bant: If ite	П	20a. Method of Disposition 1	B ☐ Removal from State	20b. Place of Dis cemetery, cr	position (Name of ematory or other plac	e) 11/	20/10	20c. L	ocation - City	or Town, State		
NOVEMBER 17, 2010 Saltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	П	4 Donation 5 Other (Sp	+ //		Valley Men			Tin	nonium,	_Maryland		
Ba	permit. Departn Imports any injt		21 Sgnate Funeral Service Dryan W. Cla	Ty		22. Name and Address Lemmon Fur 10 W. Pado	ss of Facility neral Home	e of Du	ılane	y Vall	ey Inc.		
			23a. Part 1. Enter the disease, or c shoot, or he t failure. List on	omplications that caused the	ne death. Do not er	nter the mode of dyin	g, such as cardiac o	or respiratory ar	rrest,	<u> </u>	Approximate		
	Physician/		Immediat Caus (Final disease o con lion	Atheros	chiotis	Coro.	V-1	0~/.	0.,	e-1-	Interval Between Onset and Death		
	Medical Examiner		resulting in death) Due to (or as a consequence of):										
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	ted 1 Insit	dical Examiner	cause. Enter Underlying Cause (Disease or iinjury	200 10 101 de a e	onesquentes on,								
109	ate be executed ohysician and the burial-transit	Ĕ	that initiated events resulting in death) Last	C. Due to (or as a c	onsequence of):						<u> </u>		
09	tte be hysicia he bur	Sica		d,									
687	certifical ending ph use as th	Μě	IF FEMALE:										
9 ×	eath certifica attending ph	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	Fetal death 3	Ectopic pregnanc	y		4	23d. Date of c	delivery		
Вох	the hec	by Physician/Me	1 Yes 2 No	4 □ Pregnant at tir 9 □ Unknown	me of death 5	Other (specify)	<u></u>			Month	Day Year		
P.O.	that the dened by the detached	표	Part II. Other significant condition	contributing to death but i	not resulting in the	underlying cause give	en in Part I.	23a Did to	obacco i	una contributo	to the cause of death?		
	ires the signer of the signer	qp			-	, ,					Probably 4 Unknown		
ord	v requ	lete						24a. Was			utopsy findings available		
STEPHEN Vital Records,	he lav te has age 2	Completed						autor			completion of cause of		
EP.	an: T tifica tor, p	BeC	25. Was case referred to medical	T	 -	26 Pla	ce of Death (Check	1 Yes	2 1 No	1 □ Y	es 2 No		
ST	nysici lis cei direc	일	examiner? 1 Yes 2 No	Hospital:	2 ER/Outpatie	Othe			dence 6	Other (See	noife!		
\mathbf{of}	ng Pł fter th ineral	ig i	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Ye	28b. Time o		at 2	8d. Describe h			ecny)		
BUDOSH ivision o	tendi leath. lor: A the fu	itics	2 Accident Investigat 3 Suicide 6 Could no	ion			res 2 □ No						
BUDOSH, Division of	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by completed filled in by the funeral director, page 2 should be detacted.	Certificate:	4 Homicide determine		- At home, farm, st Specify)	reet, factory, office	2	28f. Location (S City or Tow	Street and n, State)	d Number or R	ural Route Number,		
	Hospit 24 hour Funera sted fille	Medical	(Uneck 2 L Medical Exa	nysician: To the best of my miner: On the basis of exam	nination and/or inve	stigation in my opinior	death occurred at	the time date a	nd place	and due to the			
	o the		only one) 3 L Certifying N 29b. Signature and title of certifier	urse Practioner: To the bes	t of my knowledge,	death occurred at the 29c. License	time, date and place	, and due to the	e cause(s) and manner a	s stated.		
	- > - O		> Poses	2. Mon	MO		250% ×		290. Dat	e signed (Mon	th, Day, Year)		
	18)	3	30. Name and address of person wh	completed cause of death	n (Item 23a) (Type,	Print)				, , , ,	0 1 / 0		
	. 7.		ROBERT MOSS,			Y VALLEY I	ROAD	TIMONI	T UM	MD 21	.093		
1	Stat Registra		1. Date filed (Month, Day, Year)	32. Registrar's									
	H 17 Rev 7/20		NOV 23 2010	Service S.	parke								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 20. 2010 4:50PM November Maria Frieda Braun /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Wilson Health Care Center <u>Gaithersburg</u> Birthplace (State or Foreign Country) If Under 1 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1 □ M 2 X F Yrs. 1909 October 25, Germany Director 064-30-0349 101 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State ral", or items 23a or 28a-f show Exerciper oust be notified at 1 ☐ Yes 2 🔀 No Director Germantown Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20874 14905 Spring Meadows Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. and 2 should be filed within 72 hours after 1 □ Never Married 2 □ Married 1 □Yes 2 🛚 No altimore, Maryland 21215-0036 Specify: ģ 3X Widowed 4 ☐ Divorced White "natural" Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation the Medical (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) alth and Mental H 27 is marked oth r traumatic even Be Anna Maria Fuder Friderich Buehler 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14905 Spring Meadows Drive, Germantown, Maryland 20874 Walter Braun/ Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) omery Inc. 23, 2010 Bethesda, Maryland
22. Name and Address of Facility Robert A. Tumphrey Funeral Home/
Rockville, Inc. 300 West Montgomery Avenue
Rockville, Maryland 20850-2805 20a. Method of Disposition Department of H Important: If ite any Injury or ot once. 1 ☐ Burial 2 🗓 Cremation 3 ☐ Removal from State Montgomery Crematorium Inc. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee M00335 Approximate Interval Between Onset and Beath 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ona ia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 ☐ Other (specify) signed by the a 9 Unknown 23e Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u></u> 2-No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be irector, page 2 s autopsy 2□No 1 ☐ Yes this certific al director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral (28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 ☐Yes 2 ☐No death. 2 Maccident after death Director: d in by the f 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my calcium. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

To the Hosp within 24 hor To the Fune completely fi

State Registrar

29b. Signafure and ti

30. Name and add

UNN 32. Registrar's Signature 31. Date filed (Month, Day, Year

cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 36664 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 2010 1:17 P^{M} Ariel Maxine Biggs Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
July 7, 1922 9. Birthplace (State or Foreign Funeral Months Days Hours Min. Colorado 1 M 2 X F 505-20-6441 88 **Director** Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Rockville Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 20852 11710 Magruder Lane United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Force 5 ģ 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White "natural" 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Real Estate Agent Real Estate permit. Page 1 and 2 should be filed.
Department of Health and Mental Hy, Important: If item Z7 is marked other any injury or other traumative. traumatic event, Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) မ Vermal Nathan Clark Rubie Lucille Nicodemus 19a. .nformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11710 Magruder Lane, Rockville, Maryland 20852 Thomas H. Biggs / Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, November 1 Burial 2 X Cremation 3 Removal from State Montgomery Crematorium, Inc. 22, 2010 Bethesda, Maryland 4 Donation 5 Other (Specify) Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 21. Signature of Fundal Service Licensee elle Bronze 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Intracerebral Bleed Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Cerebrovascular Accident Sequentially list conditions Due to or as a consumuence of cause. Enter Underlying physician and the burial-transit that the death certificate be executed Exam Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death be detached g 🗌 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Aspiration Pneumonia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Records, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has 1 Yes 2 No the Hospital or Attending Physician: within 24 nours after death.

To the Funeral Director: After this certific complete: filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Division of Vital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ី No 1 Tes မ 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death 28d. Describe how injury occurred Certificate: injury 1 🛚 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner To the best of my moving at the time, date and place, and due to the cause(s) and manner stated. (Check 3 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D36797 November 21, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10215 Fernwood Road, Bethesda, Maryland 20817 Alan Sheff, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 3 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

✓ DHMH 17 Rev 7/2009

1317

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Dorothea Anna	в Ва	Ker Sta 1- For State Registrar	te of Marylar		artment of <i>rtificate</i> o <i>f</i>		d Mental		Reg. No. 20	10 3666		
Physic Medical Exan		Decedent's Name (First, Middle, Do:	rothea A.	Baker				2. Date of De	2. Date of Death Month Day November 8, 2010 3. Time of Death 1725 hrs			
		4a. Facility Name (if not institution, 6313 Swords Way	give street and num	nber)	ber) 4b. City, Town, or Location of Death Bethesda 4c. County of Death Montgomery					Death		
Funera Directo		5. Social Security Number 6		. Age (In yrs. 1		If Under 1 Yea Months Days			irth(MM/DD/YYYY)	9. Birthplace (State or Foreign		
		Usual Residence of Decedent	M 2XF		Yrs.			reb.	11, 1927	Massachusetts		
nd thow any		10a. State	omery		Town or Locati Sethesda	n				10d. Inside City Limits 1 Yes 2 No		
Marylar - 28a-f s	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of What	Country?		
With the s 23a or	la I	6313 Swords Way	12. Was Deced	ent Ever in U	S 13 Was	20817		Specify Yes or No	United S	tates		
ter death ', or item	Funeral	1 X Never Married 2 Marr 3 Widowed 4 Divorce			lf Ye	es, specify Cuban	, Mexican, Pue	to Rican, etc.)	White, e			
hours afi natural'	ed by	15. Decedent's Education (Specify	l or Dates: only highest grade		16a. Decedent	s Usual Occupati	ion (Give kind o		Specify:	ess/Industry		
036 ithin 72 l ne. r than "1	Completed	Elementary/Secondary (0-12)	College (1-4 5+	or 5+)	_	strative		,	Judici	al		
D 21215-0036 Should be filed within 72 hours after death with the Maryland and Mental Hygiene. T is marked other than "natural", or items 23a or 28a-f show any natic event, the Medical Examiner must be notified at once.	Be Col	17. Father's Name (First, Middle, La Andrew Bacher	st)	-		1	18.Mother's Nar Ella 1		Maiden Surname) ot availa	ole)		
Shou shou and N	ို	19a. Informant's Name/Relationship Anne C. Gregory/			19b. Mailing 9039 S	Address (Street	and Number o	r Rural Route Nur .#812, Si	mber, City or Town, S Llver Spring	State, Zip Code) MD 20901		
		20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal from	State AST	rematory or other	ion (Name of cerr er place) e		Date 22,	20c. Location - City or Town, State Ware, Massachusetts			
Baltimore, permit, Pages I as Department of He. Important: If ite		4 Donation 5 Other Spec 21. Signature of Funeral Sovice Lice	ify:	Ce	metery	me and Address	of Facility IMD hrev	2010 Funeral	Home /Beth	esda-Chevy		
Physician	_	23a. Part I. Enter the disease, or col	nplications that caus	M0019 sed the death.	o 1/55	/ Wiscon	sin Ave	., Bethes	sda, MD 20	814-3501		
/Me in al Examiner		23a. Part I. Enter the disease, or confailure. List only one cause on Immediate Cause (Final disease or condition resulting in death)				rosclero nic Obst	tic Ca ructive	rdiovásc Půlmona	cular Dise	tween Onset and Death		
	L	Sequentially list conditions. b										
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60, tte be ext hysician e burial -	Medical	X UNPENDED	AMENDED 2			911 1–6	-11 vt		Look part (d)			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 ✓ No 9 Unknow	1 Live birth	t at time of dea	2 Feta	I death 3	Ectopic pregr	nancy	23d. Date of del Month	very Day Year		
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ital Rician: 1	Be C	25. Was case referred to medical examiner?	Hospital:				of Death (Check	only one)				
1 of V ing Phys After thi funeral di	n: To	1 Yes 2 No 27. Manner of Death	28a. Date of I (Month, Da	njury	ER/Outpatient 28b. Time of Inju				Residence 6 🗸 O	ther: Scene		
ivision or Attendi after death. Director:	ertification:	1 X Natural 5 Pending Punyestiga	ition 280 Place of		me farm street	1 Ye	s 2 No	28f Location (S	treat and Number or	Rural Route Number, City		
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Division To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	Medical	(Check only 1 ☐ Certifying Physi one) 2 ✓ Medical Examine	cian: To the best of er:On the basis of e and manner state	xamination an	e, death occurre d/or investigation	d at the time, date n, in my opinion, o	and place, and death occurred	d due to the cause at the time, date a	e(s) and manner as s and place, and due to	stated. the cause(s)		
H % H S	ž	29b. Signature and title of certifier	1 N			29c. License O.C.M		OCME	29d. Date signed (
e o		30. Name and address of person who	1	/		0.0.1	· <u>-</u> ·		November 9, 2	.010		
geni s	ate	Theodore M. King, Jr., M. 31. Date filed (Month, Day, Year)		Medical Ex		11 Penn Stre	et, Baltimor	e, MD 21201				
Regis	trar	NOV 2 3 2010	Even &	trar's Signature	Kel							

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or ite any filury or other traumatic event, Item Addent Exer. Saltimore, Maryland 21215-0036

Physician - /Medical Examiner

or Attending Physician; The law requires that the death certificate be executed burial-transi Box 68760 P.O. I Records, of Vital After Division

1. Decedent's Name (First, Middle, Last) **Physician** 19, 2010 November Ercell May Huff Bruzee /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Wilson Health Care Center Montgomery Gaithersburg If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🖺 F 329-18-5232 100 May 4, 1910 Director Virginia Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location items 23a or 28a-f show the Medical Exeminer must be notified at 1 XYes 2 No Director Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 301 Russell Avenue # 346 20877 United States Funera Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2 🖾 No White Specify: ð 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Public Health Elementary/Secondary (0-12) College (1-4or 5+) Washington, D.C. Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Preston Huff Venetta Martin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Alan Bert Bruzee, Jr. / Son 813 Aster Street Rockville, Maryland 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1₺ Burial 2 Cremation 3 Removal from State December 6, Cedar Hill Cemetery Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2010 22. Name and Address of Facility 1/seta Robert A. Pumphrey Funeral Home Rockville, Inc. 300 W. Montgomery Avenue Rockville, Maryland 20850 MO1607 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Congestive heart failer Oreday disease or condition resulting in death) Due to (or as a consequence of): Sypertensive Sequentiany liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in the cause) Examiner that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed the orthertes 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2⊞No မ 28b. Time of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1 Roberts 04115 Nozember 19, 2010 201 RUSSELLAVENUE 30. Name and address of person who completed cause of death (Item 33a) (Type, Print) I.J. ROBERT BIRSCHBACK NUM 641THERSBURG, ULD 31. Date filed (Month, Day, Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Maryland				d Mental Hy	giene	1 0	00003
			1 - State Registrar		Cer	tificate of L	Death		Reg. No.	10	3666/
	Physicia	NAVIII DOLKIJALALIA						2. Date of De. Month Novembe		20 ^{Ye} ar	3. Time of Death 2:33 P M
	Medic Examin		4a. Facility Name (if not institution, give st		4b. City, Town, or	Location of De		4c. County		1 2.33 1	
	}		Holy Cross Hospita	11		Silver	Spring		Mont	tgomer	сy
	Funeral Director			7. Age (In yrs. late	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		19 [°] 1936	9. Birthp Coupi Ind	place (State or Foreign tsy) 1a
	on now	_	Usual Residence of Decedent 10a. State 10b. County	10c City	, Town or Loc	ation				1	0d. Inside City Limits
	arylar ta-fsh	ecto	Maryland Prince Ge		elphi					- 1"	1 ☐ Yes 2 X No
	or 28	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	itry?
	s 23a	era	10001 Riggs Road			20783			Unite	ed Sta	ites
320	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fur	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 	If	/as Decedent of Hi Yes, specify Cubar ☐ Yes 2 🛣 No	n, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	Bla	ce - America ck, White, e	
ž	hours natura lical E	lete	15. Decedent's Edu		16a. Deced	ent's Usual Occupa	ation		16b. Kind of B	usiness Inc	dustry
212	iin 72 ie. han "i	ошо	(Specify only highest grade Elementary/Seconday (0-12)	e completed) College (1-4 or 5+)	life. DC	ind of work done d NOT use retired)	luring most of w	vorking	i e	ı Temp	•
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Maryland 21215-0036	id be file Mental H arked o i atic ever	To B	17. Father's Name (First, Middle, Last) Unobtainable			18. Mother's N	Maiden Surnam	len Surname)			
, Mar	d 2 shou alth and r 27 is m er traum		19a. Informant's Name/Relationship (<i>Type</i> Vikram Kushawaha/					Rural Route Numbe Silver S	-		
Baltimore,	of He of He if item		20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ R	20b. Pl	ace of Dispos	sition (Name of		ember 19.	20c. Location		
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ga	permit Depar Impor any in		21. Signature of Fureral Serving Ligenses	MO1607	P 22.	Name and Addres obert A. 557Wiscor	s of Facility Pumphre Isin Ave	ey Funeral enue Beth	HomeBethe esda, M	sda-Ch aryla	nevyChase, Inc. nd 20814
	Physician/		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	cations that caused the death. cause on each line. Failure To			g, such as cardi	ac or respiratory am	rest,	W	Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a conseque		ate Carci	inoma			Y	ears
	_ +	iner	Sequentially list conditions, if a year go in model cause. Enter Underlying Cause (Disease or linjury	Directo (or as a conseque	onto off						
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2/00/	ificate ig phy as the	Med	IF FEMALE:								
DOX DO	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnan 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 🗌	Ectopic pregnancy Other (specify)	у			ate of delive	ory Day Year
7. Ö.	at the		Part II. Other significant conditions cont	tributing to death but not resu	Ilting in the un	iderlying cause give	en in Part I.	23e. Did to	bacco use cont	ribute to th	e cause of death?
as, r	quires t en sign ould be	ted by					<u> </u>	_ 1 🗆 '	Yes 2 No	3 Prob	oably 4 🛚 Unknown
Vital Records,	he law re ite has be age 2 sho	Completed						24a. Was a autop perfo	rmed?	Were autop prior to con death? 1 \(\subseteq \text{Yes}	osy findings available inpletion of cause of
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_	Physic this co	은	I Li fes 2 124 No	ospital: 1 Npatient 2 E 28a. Date of injury			4		dence 6 Other (Specify)		
o uo	ending F eath. or; After he funer	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28b. Time of injury	28c. Injury work? M 1 🗆 Y	at ? Yes 2 🗆 No	28d. Describe h	e how injury occurred			
DIVISION OF	tal or Att rs after d al Direct led in by t		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, stree	et, factory, office		28f. Location (S City or Tow	Street and Number or Rural Route Number, vn, State)		
	e Hospi 24 hou e Funer bleted fill	Medical	(Check 2 L Medical Examine	ian: To the best of my knowle r: On the basis of examination Practioner: To the best of my l	and/or investig	gation, in my opinior	n, death occurre	d at the time, date a	nd place, and due	e to the cau	se(s) and manner stated.
	To the within To the Comp		29b. Signature and title of certifier			29c. License			29d. Date signed		
			>/ - grapha			D3233	12		11/16	/2010	
_			30. Name and address of person who con Suresh K. Gupta, N	-			te 220	Silver S	pring, h	Mary1	and 20902
١	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ire Ke						

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AMEND ITEM#4a-c, perPHYS, g909, 11/23/2010, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 12^{Day} 2010^{Year} Physician/ Nov 9:45 P M Budzik Elizabeth Joanne Medical Facility Name (if not institution, give street and number)
Fighaptic Ocean Unboard Ship 4b. City, Town, or Location of Death **Baltimore City Enchantment** of 4c. County of Death **Examiner** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 TxF Months Days Hours Min. June 22, 1942 Maryland 68 **Director** 216-40-1561 Usual Residence of Decedent or 28a-f show notified at and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Dunda1k 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21222 7350 Manchester Road United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 🕱 No Black White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give 3 - Widowed 4 - Divorced Completed Year or Dates White 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own_Home 12 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Joseph Kahler Dorothy McCloskey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Florian M. Budzik (Husband) 7350 Manchester Road Dundalk, Maryland 21222 permit. Page 1 and 2: Department of Health Important; If item 27 any injury or other troones. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Oak Lawn Cemetery 11/18/2010 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 7922 Wise 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Acute myocoldal inforction disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 20 yeas -Oronary affery disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine the burial-transit The law requires that the death certificate be executed Cause (Disease or linjury and a that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown signed by the at Id be detached for g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Diebet CS mentos type 2 Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Atrist Fibrilation page 2 autopsy certificate has 1 ☐ Yes 2 🗷 No 25. Was case referred to medical Division of Vital or Attending Physician: completed filled in by the funeral director, 26. Place of Death (Check only one) Be Onboard ship examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 2<mark>₹</mark> No 1 Tes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred iniury 1 Natural 5 Pending 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Zertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗆 (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ROD, M.D 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** ovember 2.48 AM 2010 Catherine С. Blair 13 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Agnes Baltino re HOSPITA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. Months 1 □ M 2 😾 F Director 26, 1923 217-18-6751 86 Maryland Dec. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, I's Medical Examiner must be notified at 1 ☐ Yes 2X No Directo MD Baltimore Randallstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4407 Chapeldale Road Funeral 21133 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 🙀 No ģ Specify: 3 ₩ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) <u> Housewife</u> Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Byrnes Genevieve McDonald ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important; If item 27 is any injury or other trai once. Linda K. Burroughs Daughter 1065 Downton Road Arbutus, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Lake View Mem. Park 11/20/2010 Sykesville, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 11824 Reisterstown Road alren ELINE FUNERAL HOME Reisterstown, MD 21136 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Preumonia Immediate Cause (Final **Physician** day disease or condition resulting in death) } /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate data. Enter Underly Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and Due to (or as a consequence of) 68760 Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) P.O. 9 HInknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate 1 ☐Yes 2 XNo 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1. Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28b. Time of Injury 27. Manner of Leath 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No s after death filled in by the 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral I 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 64583 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sq. Agnes + (03 ps+ ad 10 MD Mitikis D. MD Visupama 21229 900 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Leray Bess Nevaeh A 0/ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death oseda Balt Square rankin HOS Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗡 F Hours (Month, Day, Country) Director 0 N/A 2010 Maryland Usual Residence of Decedent fshow 10b. County Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Dundalk 1 Yes 2 XNo Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Nevaen Funeral 21222 USA 1900 Tolson Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. Completed by 1 X Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: Bi Racial 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) N/A N/A Be Maryland 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) 2 Tiffany Pruitt Leroy Bess 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tiffany Pruitt Mother 1900 Tolson Avenue, Dundalk, Md. 21222 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State November 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Bayview Crematory 22, 2010 Signature of Furieral Service Licensee ²²Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease, Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) mate Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death 2 No the 9 Unknown 11 9 Unknown 2010 been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? Director: After this certificate 1 🗆 Yes 2 🗆 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? Natural 5 \square Pending Accident
Suicide
Homicide 2 🗌 No Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funeral Dire Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one 29b. Signature an**g**title of certif 29d. Date(signed (Month, Day, Year) 00026820 con who completed cause of death (Item 23a) (Type, Print) 30. Name and address of p : MOLE, MD 21237 Franklin Square Drive 32. Registra 's Signature State 3 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 20b. per Fh g909 11/23/10 TT

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 10 50 PM **Physician** NOV 17 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE SAINT AGNES HOSPITAL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Company | Min. | Co 9 Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Maryland Maryland **Funeral** Year) 216-30-622 Usual Residence of Decedent 1 □ M 2 🗓 F 216 Yrs. Director the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show r than "natural", or items 23a or 28a-f shouts Madical Examiner must be notified at 1 Yes 2 □ No **Funeral Director** more 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 2 Items 23a Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 □Yes 2 No Specify. ≥ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Relations Special C 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be traumetic ပ 1 Brow (daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21133 19a. Informant's Name/Relationship (Type. Print) Donogh Randallstown sawn other 20a. Method of Disposition
1 ☐ Burial 2 ★ Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 11/29/2010 Department of Important: If it eny Injury or o 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Funeral Home, Joseph 2222 W. North 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CANCER years /Medical Due to (or as a consequence of) Examiner Failure Days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): or Attending Physicien: The law requires that the death certificate be executed physician and the burial-transit Hyperte

Due to (or as a consequence of): YEAVS O. Box 68760 Be Completed by Physician/Medical EITA attending p for use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year signed by the a Id be detached fo 5 Other (specify) 1 □Yes 2 No 9 Unknown 9 ☐ Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 Probably 4 Unknown 2 🗌 No 1 Yes certificate has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 0 autopsy performed' Vital 1 ☐ Yes 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 LInpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To After this Division of 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident by the 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in the Hospital to the cause(s) and manner as stated. 29a, Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie ပ္ 00 69 177 NOV 17 2010 MD Mohammad 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Battimore 21229 AVE HOSDITAL 400 cator valikhan AGNES 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1, Decedent's Name (First, Middle, Last) Dav Month Year **Physician** 18 Valerie Corbin 2010 7:56 Nov. Α /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard Howard County General Hospital Columbia 8. Date of Birth (Month, Day, Y July 20, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Year) 1957 Hours Min. Davs 53 Months 1 □ M 2 🛛 F Maryland 215-76-1273 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a, State 28a-f show ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the theologic Experiment is ust be multified as 1 □Yes 2 No Ellicott City Funeral Director MD Howard 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 21043 United States 4662 Round Hill Road e filed within 72 hours after death val Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Tyes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 ☐ Widowed ♣️ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Landscaping Landscaper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Menta Marilyn Mann Joseph Phelps 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 709 Park Ridge Dr., Mt. Airy, MD 21771 27 Shannon Logue, Daughter Department of Healt Important: If Item 2 any injury or other once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/22/10 Baltimore, Maryland Metro Crematory Inc. 4 □ Donation 5 □ Other (Specify) Signature of Funeral Service Lionsee Thomas Gregor 22. Name and Address of Facility Cremation Society of Maryland Momon 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Immediate Cause (Final Complication of Pneumonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Airway Obstruction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner death certificate be executed ending physician and use as the burial-transi Cardiac Arrest resulting in death) Last Due to (or as a consequence of): Physician/Medical ettending p for use as IF FEMALE yes, outcome of pregnancy

Live birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 5 Other (specify) signed by the e 1 ☐ Yes 2 📉 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. ģ Ex-Smoker 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown s peen s Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ▼No Asthma 24a. Was an performed certificate I 2 No 1 X Yes funeral director, 25. Was case referred to medical 26. Piace of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of injury (Month, Day, Year) 28b. Time of injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation al or Attendi after death. 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af

To the Funeral D

completely filled in t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

P.O. Box 68760. Division of Vital Records, Hospital

> State Registrar

YOUNG

(Check only

29b. Signature and title of certifie

M.D.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 22,2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ST. BALTIMORE, MD 1650 ORLEMUS

31. Date filed (Month, Day, 32. Registrar's Signature 23

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 19 Month Physician/ Thomas Joseph-Harris Clark 11:51 PM November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 908 Quantril Way Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) Funeral (Month, Day, 1 🏋 M 2 🗆 F Days Hours Pennsylvania Months Yrs 1969 41 Director 195-58-6945 May Usual Residence of Decedent 28a-f shov Examiner must be notified at 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1X Yes 2 ☐ No Maryland N/A Baltimore 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 908 Quantril Way 21205 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 73 Department of Health and Mential Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) / Export Manager Import Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Thomas Joseph Clark Joan M. Murtha 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 908 Quantril Way Baltimore, Maryland 21205 Sandra Lynn-Harris Clark, Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Metro Crematory Inc. 4 Donation 5 Other (Specify) 11/22/10 Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor emation Society Of Maryland, Inc. 9 Frederick Road Baltimore, Mary 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to or as a consequence of): Examiner Stoma Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying -transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events +mber and Due to (or as a consequence of) resulting in death) Last the burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? ó Year Month Day Pregnant at time of death 2 No detached g Unknown a Unknown as been signed by 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy page performed death? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA မ 1 🗌 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural iniury 5 Pending s after death. 1 ☐ Yes 2 ☐ No 2 Accident Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completed filled in by determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 111 2010 1303 thed 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#16a, perFH, G909, 11/23/2010, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOUTH Day 21 2010 Thomas Vincent Carson 8:09 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner 4h City Town or Location of Death BALTIMERE SAINT JUSEPH MEDICAL CENTER TOWSON cial Security Numbe If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. March 30, 1945 Director 212-44-6522 65 Baltimore, Maryland Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County the Maryland 10c. City. Town or Location 10d. Inside City Limits Director Maryland **Paltimore County Lutherville** 1 Tes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural" any injury or other trainment. Funeral 1 Spring House Road 21093 **United States** Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 K No Specify: White If Yes, Give Vietnam Year or Dates. Specify: Completed 3
Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) Mortgage Broker

Mortuge Broker 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Financial Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George J. Carson, Sr. Florence R. Harris 19a. Informant's Name/Relationship (Type, Print) (wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Francesa Mary (nee Bertuca)Carson Lutherville, Maryland 1 Spring House Road 21093 c. Location - City or Town, State (Paltinore Corrly) 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Wednesday 4 Donation 5 Nother (Specify) Moreland Menorial Park Baltimore, Maryland Nov. 24,2010 22. Name and Address of Facility **Peaceful Alternatives Funeral & Cremation Center**, P.A. Signature of Funeral Service Licensee Robert O. Biedelman Lic.#M01445 2325 York Road Timonium, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physiciani PROSTATE CANCER a. Due to (or as a consequence of): day Medical resulting in death) Examiner STROFNTESTINAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or iinjury use as the burial-tran that initiated events resulting in death) Last and attending physician Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Wunknown Completed After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performe 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 🗌 Yes 2 🗹 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 24 hours after death Funeral Director: completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHHIM D 7601 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

3 2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Zo Year CHIPPICH KATHERINE MARIE 5: 47 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOWARD COUNTY GENERAL MUSPITAL HOWARD CODDINGIA 8. Date of Birth (Month, Day,) Apr 13, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Year) 19<u>43</u> 1 □ M 2 🛛 F Days Hours Pennsylvania Director 67 206-32-6570 Usual Residence of Decedent or 28a-f show 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location event, the Medical Examiner must be notified at Director 10d. Inside City Limits 1 Yes 2 No Prince George Laurel 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral items 23a 8503 Snowden Loop 20708 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. ò <u>\$</u> 1 Never Married 2 Married 2 X No Yes Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. I other than " United States life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H ည permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic once. Frank Kron Anna B. Crame traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph J. Chippich 8503 Snowden Loop, Laurel, Maryland 20708 Baltimore, 20a. Method of Disposition 20h. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Vet. Cem. Nov 29,10 Crownsville, Maryland 22. Name and Address of Facility
Donaldson Funeral Home, P.A.
313 Talbott Ave. Laurel, Maryland 20707-4389 . Signature of Funeral Service License M00773 23a. Part 1. Enter the distance, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hand far ure. List only one cause on each line. Immediate Cause (Final Onset and Death SHOCK Physician/ SEPTIL disease or condition 2 WEEK Medical resulting in death) Due to (or as a consequence of) Examiner PNEUMONIA WELKS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by BRETTET CANCER Division of Vital Records, 1 Yes 2 No 3 Probably 4 Nonknown 24b. Were autopsy findings available prior to completion of cause of death? AUMIASIA 24a. Was an autopsy performed? Yes 2 \(\text{No}\) MAZIGNANT PLOURAL GARUZ. ON 1 Yes 2 No is after death.
I'm by the funeral director, pe 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: ၉ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending injury work? 2 🗆 No ☐ Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 🗌 Homicide determined Medical 1 Vertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

Registrar

32. Regis ar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) O. NYANJOM My

1) 36974

10710 CHARTER DRIVE #310

29d, Date signed (Month, Day, Year)

WILLIAM NO 21024

2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#19a, perFH, G910, 12/1/2010, WS

State of Maryland / Department of Health and Mental Hygiene 36676 State
Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death
4:28 PM Physician/ Month Year Elaine S. Calhoun Medical 4a. Facility Name (if not institution, give street and number) Examiner 4h City Town or Location of Death 4c. County of Death Union Memorial Hospital Baltimore Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Ye Hours Mary Land 213-26-6564 80 Director Ĩ′930 June Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Catonsville 1 ☐ Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 717 Maiden Choice Ln. ST 425 21228 **USA** Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White Completed 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Disaster Worker American Red Cross Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Charles Smith Theresa Zimmerman 19a. Informant's Name/Relationship (Type, Print)
Barbara A. Leland (Pe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Per. Rep.) 423 Pineapple Square S.W., Vero Beach, F1. 32962 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 🗖 Other (Specify) Entombment Loudon Park Cemetery 11/29/10 Baltimore, Maryland 21. Signature of Funeral Service Licen 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between and Death Immediate Cause (Final Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Examiner attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy performe certificate 2 No ☐ Yes 2 🖫 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after deau..

To the Funeral Director: After this any one of the funeral director is a completed filled in by the funeral director. 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier AT-2438946 NOV, 19,2010 MOHAMMADALI 2 4 ITTMORIZ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NOVEMBER 2010 BARNEY COHEN 1:00 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NORTHWEST HOSPITAL CENTER BALTIMORE RANDALLSTOWN Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min 12/31/1916 Director 115-03-5468 93 NY Usual Residence of Decedent show or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3041 FALLSTAFF ROAD, #307 21209 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 XYes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify Completed 3 ♥ Widowed 4 □ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. I other than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SALES TELEPHONE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental & 27 is marked c traumatic eve ပ **JACOB** COHEN ANNE **GERSH** 1 and 2 should by the Health and Mer item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHELLEY COHEN/DAUGHTER 3004 HERNWOOD ROAD, WOODSTOCK, MD At. Page 1 and Lepartment of Health Important: If iterany injury or any injury or once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BETH EL MEMORIAL PARK 11/21/2010 RANDALLSTOWN, MD Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final 24 HOURS Physician/ ACUTE MYOCARDIAL INFARCTION disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** SEPSIS 24 HOURS Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month the 9 Unknown signed by t Part II. **Other significant co**nd**ition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> PNEUMONIA, ACUTE RENAL FAILURE, URINARY TRACT Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No INFECTION, HYPERNATREMIA 24a. Was an has autopsy performed? Yes 2 No certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 **X**No Other: ၉ 1 Nation 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Il Director; After this od in by the funeral d 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

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only one) 29b. Signature and Ith

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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DHMH 17 Rev 7/2009

29d. Date signed (Month, Day, Year)

Smith Ave #203, Baltimore MD 2126

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER MILTON CAPLAN 18, 2010 7:03 AM Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE BEST CARE ASSISTED LIVING REISTERSTOWN 7. Age (In yrs. last birthday) **Funeral** Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Hours (Month, Day Year) 05/22/1918 Director 218-10-1626 92 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho idical Examiner must be notified at Director 1 ☐ Yes 2x☐ No MD BALTIMORE REISTERSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 639 MAIN STREET 21136 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Force Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: If Yes, Give 3 Widowed 4 Divorced WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) COURIER BANK OF AMERICA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ NATHAN CAPLAN LENA GOLDSTEIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra LAURIE SAPERSTEIN/DAUGHTER 22 HARROD COURT, REISTERSTOWN, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Nurial 2 Cremation 3 Removal from State cemetery, crematory or other place, EMUNAHRAITZ 4 Donation 5 Other (Specify) 11/21/2010 BALTIMORE, MD Exture of Fullieral Service Licensee SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 8900 REISTERSTOWN ROAD, PIKESVILLE, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Atheroscletic CArloskso disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** 4 45 Sequentially list conditions, Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): resulting in death) Last Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 __ Live Birth 2 __ Fetal death 23b. Was decedent pregnap 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Atv.s 2 No 1 Yes Yes 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Hospital 2 No ASSISTED 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 - Homicide determined City or Town, State 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signat ire and title of certifie 29c. License number

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day,

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ddress of person who completed cause of death (Item 23a) (Type, Print)

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Dhysicia		Registrar 1. Decedent's Name (First, Middle,Last)		Reg. N 2. Date of Death		3. Time of Death		
Physicia: ∵çal Examin		Stephanie L. Chenoweth		November 15	y Year 5, 2010	1612 hrs		
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat	h	4c. County of Death			
		323 Nature Walk Lane	Pasadena	Data of Dieth (8	Anne Arundel	hplace (State or Foreign		
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hr Months Days Hours Mi	n	Cou	intry)		
Director	Į	$214-56-4865$ 1 M 2 \overline{X} F 60 Y	rs.	04/12/1	950 Mai	ryland		
any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	ation			10d. Inside City Limits		
		Maryland Anne Arundel Pasadena				1 Yes 2 No		
Sa-f st	rector	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cour	ntry?		
r death with the Maryland or items 23a or 28a-f show must be notified at once.	E I	323 Nature Walk Lane	21122		II.S.A.			
with with se 23s	īa	11. Marital Status 12. Was Decedent Ever in U.S. 13. V	Vas Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puerl	Specify Yes or No-	14. Race - Americ White, etc.	can Indian, Black,		
death or iter	ŭ.	1 Never Marned 2 Married 1 Yes 2 X No	_	,	Caraltii T71			
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5-0036 iled within 7 Hygiene. I other than	Completed	17. Father's Name (First, Middle, Last)		ne (First, Middle, Mai	den Surname)			
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "matural", or items 23a or 28a-f sho natic event, the Medical Examiner must be notified at once	Be	Chester Sherman	Betty ling Address (Street and Number of	B. IB. I D. II	- Cit Tour State	Tracey		
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Baltimore, Normit. Pages 1 and Department of Health Important: If item injury or other trau		1 Burial 2 ACremation 3 Removal from State crematory of	other place)	/10/2010	Class Day	oio Morylon		
timent rtant:						nie, <u>Marylan</u>		
Baltimore permit. Pages 1 Department of 1 Important: If i		21. Signature of Furieral Service Licenses	2. Name and Address of Facility McCully—Polyniak 3204 Mountain Roa	Funeral H ad Pasaden	ome, P.A. a, Marylan	nd 21122		
Physician	_	23a. Part. Enter the disease, or complications that caused the death. Do not enter	er the mode of dying, such as cardiac	or respiratory arrest	shock, or heart	Approximate Interval Between Onset and		
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Salicylate intox:	ication			Death		
Examiner		or condition resulting in death) Due to (or as a consequence of):						
	10	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	<u> </u>					
	nin	cause. Enter Underlying Cause						
ed sit	Examin	events resulting in death) Last Due to (or as a consequence of):						
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. After this certificate has been signed by the attending physician and npletely filled in by the funeral director, page 2 should be detached for use as the burial - transit	cal	☐ AMENDED 23a,27,28a-f, pe	- ME -010 12/7/10) mm				
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68760, certificate be nding physic ise as the bur	an/I	23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic preg	gnancy	Month	Day Year		
Box 687 e death certific the attending p ed for use as ti	sici	past 12 months? 4 Pregnant at time of death 5	Other (Specify)					
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ords, w requir is been s	ete			24a. Was an autopsy	prior to	utopsy findings available completion of cause of		
Records, The law require freate has been signated by the second sign	Completed			perform 1 Yes 2		es 2 No		
Vital Rec sysician: The l this certificate l director, page	ပိ	25. Was case referred to medical	26.Place of Death (Che	ck only one)				
Division of Vital Rec lal or Attending Physician: The stare death. "I be the chair scrifficate led in by the funeral director, page	9 B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa			esidence 6 🗸 Othe	er: Scene		
1 of Jing Ph After t funeral	Ë	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time	XX No		ingested	drug		
ttendi death. ctor: y the f	atic	Natural 5 Pending Investigation Fd 11.15.10 Fd 4 2 Accident Fd 11.15.10 Fd 4 28e. Place of Injury - At home, farm,	•00 рш —		_			
ivis lor A after Directed in by	Certification:	3 \(\text{Suicide} \) Suicide 6 \(\text{Could not be determined} \) Could not be determined (Specify) Found: resi		Pasader	123 Natu	tural Route Number, City TE Walk Lane		
D ospital hours ineral y fille	Ö	4 Homicide determined (Specify) FOUTIGE FESTIGETICE PASAGETTA, FID 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the f	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigations.	stigation, in my opinion, death occurre	ed at the time, date a	nd place, and due to t	the cause(s)		
To To To To To To To To To To To To To T	Med	and manner stated. 29b Signature and title of certifier	29c. License number		29d. Date signed (M			
		1/ Natorleans	O.C.M.E.		November 16, 2	2010		
		30. Name and address of person who completed cause of death (Item 23a)		4004				
			enn Street, Baltimore, MD 2	.1201				
		31. Date filed (Month, Day, Year) 32. Registrar's Signature	E. C.					
Regis	ще	MILLA COLO MANAGEMENT CA						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ever November [3:54AM 18 2010 ERALD Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Secours HOSPITAL more 7. Age (In yrs. last birthday) If Under If Under 24 Hrs. 8. Date of Birth b. Birthplace (State or Foreign **Funeral** Hours Min Director 62 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Himore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 🔀 No 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ (Sister) 19a. Informant's Name/Relationship (Type, Print) State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 20a, Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State 4 Donation 6 Other (Specify) 21. Si mature Fun al Service Licens 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ TYDEARDIAL disease or condition resulting in death) Medical Due to (or as a consequency of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Daw to for as a consequence on Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Dav Pregnant at time of death g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Vunknown this certificate has been s ral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 2 🗌 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 24 hours after death. Funeral Director: After Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I only one) 29b. Signature and 23/2010 D41734 person who completed cause of death (Item 23a) (Type, Print) Baito. 2000 W. Baltimore hRISTINE MD SON 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ROBERT CLAUDE ROLAND DAFFE 7:00a^M Medical November 201 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Greater Baltimore Medical Cente Baltimore Towson r 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Year) an 5, 1964 1 **X** M 2 □ F 434-79-0572 46 Director Jan Burundi Usual Residence of Decedent or 28a-f shov notified at shov 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Baltimore County Stevenson 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? th and Mental Hyglene. 27 is marked other than "natural", or items 23a or traumatic event, the Merical Examiner must be I Funeral 8400 Green Spring Avenue 21153 Belgium Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Daffe Robert Itimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 Divorced 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secondary Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ρ Claude Roland Daffe Rita Lammens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Judith P. Daffe 8400 Green Spring Avenue,, Stevenson, Maryland 21153 (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State St Charles Borromeo Gem 11/22/2010 Pikesville, Maryland 4 Donation 5 Other (Specify) Signatura of Funeral Service license

Martin D. Lawson MITCHECLOWIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ breast ancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or impury that initiated events attending physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Year 5 Other (specify) 1 Yes 2 2 9 Unknown the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate 2 🖳 2 🗌 No 1 🗌 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred hours after death. Ineral Director: After 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Hospital 24 hours Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Definition in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. D0060721 November 'Koukudo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

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6-BMC

32. Registrar's Signature

Falcon

Roluardo

31. Date filed (Month, Day, Year)

2010

North Charles Street Baltimore, MD 2120

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Roger Downard Lee Physician/ Month Year November 2010 :30 ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Baltimore 4c. County of Death Joseph Richey Hospice 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) OH 1 🖾 M 2 🗆 F Months Days Hours (Month, Day, Year) 232-58-2726 Director 73 June 27. 1937 Usual Residence of Decedent Show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must he mattered at 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at. 10a. State 10c. City. Town or Location 10d. Inside City Limits Director VA Prince William Woodbridge 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 12701 Inverness Way 22192 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 X Yes 2 No Navy Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give White Specify. 3 - Widowed 4 - Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Engineer Eneineenin Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Ellsworth Downard Tressa Leach 19a. Informant's Name/Relationship (Type, Print) Megan Lee Canady / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 12701 Inverness Way, Woodbridge, VA 22192 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Final Journey Crem. 11/25/2010 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Disease Liver disease or condition Medical resulting in death) Due to (or as a consequence Examiner Pulmonary obstructive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of): the attending physician Physician/Medical The law requires that the death certificate be 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box 3 - Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Day signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ś 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 🗌 Yes 2 🗌 No 1 ☐ Yes 2 🕶 Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 10 2 🗷 No Other: J Richey 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this Hospice o funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Naturai 5 Pending work Division Investigation 6 Could not be 1 Yes 2 No Accident nours after death 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Hospital 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifi 29d. Date signed (Month. Day, Year) Physician 53275 Nov 21, 2010 30. Name and address Wolfe Street ss of person who completed cause of death (Item 23a) (Type, Print) DONG NGUYEN MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

DOWNARD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month MARIE 12:10 PM KIM il 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNIVERSITY OF MARYLAND MEDICAL CENTER BALTIMORE BALTIMORE 9. Birthplace (State or Foreign Country)
D • C • If Under 1 Year | If Linder 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 5. Social Security Number 214-23-0337 **Funeral** 1 □ M 2 🟋 02/19/ 33 Director Usual Residence of Decedent 28a-f shov 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Me tical Examiner must be notified at by Funeral Director Prince George MD Landover 1

Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? items 23a or Dodge Park Road#202 20785 permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene, Important: If item 27 is marked other than "any injury or other traumation." 3413 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 2 **X** No 1 Yes 2X No Specify: If Yes, Give Specify: Black 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Secretary RNC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Ossie Durant, Sr. Roberta Gaskins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7501 Buchanan St, # 102, Landover Hills, MD Roberta M. Durant Mother 20b. Place of Disposition (Name of cemetery, crematory or other place)
Final Journey Crem. 11/23/2010 20a. Method of Disposition 20c. Location - City or Town, State 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21203 ∜Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ANOXIA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** SPINAL SHOCK Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) HYPERCOAGUABLE Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last ng physician ar Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1.☐ Yes 2 ☐ No Day Year Pregnant at time of death Yes 9 Unknown Linknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Was a... autopsy performed cate has t 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 힏 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director; After this 28a. Date of injury 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No М Accident Investigation filled in by the Suicide 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d

To the Funeral Direct
completed filled in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatur 29c. License number 1427217199 NPI 18/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TOHN S. VORRAS 1 22 S. G GREENE BALTIMORE ST. MD 21201

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene T - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Marie Wiggins Month V Derr 200 01:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BACTIMORE tos PITAL ACINES If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 1 □ M 2XX Months Days Hours 212-42-8357 69 Yrs Director 06/27/1941 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and: If item 27 is marked other than "natural", or items 23a or 28a-f show ant; If item 27 is marked other than "natural", or which traumatic event, Ire "Magial Exprints", rull be notified at my or other traumatic event, Ire "Magial Exprints", and Item notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 820 South Canton Avenue 21229 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ⊠No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: 3 Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Nurses Assistant <u> Health Care</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Andre Pitts Evelyn Hill ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andre R. Wiggins / Son 4205 Elsa Terrace, Apt. 10, Baltimore, Department of Healt Important: If item 2 any Injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 11/25/2010 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crem. Woodbine, MD 22. Name and Address of Facility 21. Signature of Funeral Service Lie vseeDorota Marshall Maryland Cremation Services PO Box 1413, Baltimore, MD 21203 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final RENAL FAILURE CUTE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner WCER KITH METASTASES SMALL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physlcian: The law requires that the death certificate be executed attending physician and for use as the burial-transit IVER METASTASES Exami that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths? Month Day Year 5 ☐ Other (specify) signed by the a d be detached for 1 ☐ Yes 2 🖺 No 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ TYPE YPERTENSWN 1 Yes 2 No 3 Probably 4 Unknown Completed HERPES ZOSTER 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 1 ☐ Yes 2 1 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No ပ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

Registrar

State

DHMH 17 Rev 1/2001

CATON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MOKURI

SAMUEL

31. Date filed (Month, Day, You NOV 2 3 2010

900

32. Registrar's Signature

2010

BALTIMORE MD 21229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Jorenhen Day 19 DANNENMANN Physician/ 2010 :56 AYMOND Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hornins Liner N/A 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 | F Months Days Hours Min. Country) Maryland 217 34 3135 73 Director Usual Residence of Decedent or 28a-f show notified at Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No Anne Arundel Baltimore Maryland 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? "natural", or items 23a or Funeral with 21225 U.S.A. 4406 Belle Grove Road within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 K No Black, White, etc. ģ 1 X Never Married 2 Married 21215-0036 1 ☐ Yes 2 K No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed White er than "natur , the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Laborer King Syrup 8th and Mental Hygie is marked other Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked oth any injury or other traumatic event, Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph J. Dannenmann Katherine Zebron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Victor / sister 4406 Belle Grove Road Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Baltimore, Maryland Bavview Crematory 11/22/2010 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a Part 1 Enter the disea shock, or heart failure. List Immediate Cause (Final Onset and Death Ph sician/ DYCIZHYthmia innediste CANDIAL disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner mored . wt Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last enten. Disepse burial-transi CONUMBAT Due to (or as a consequence of) physician Physician/Medical Box 68760 the as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the at P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed consective heart for 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed? Yes 2 2 No 1 Yes Division of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No n 24 hours after death.

le Funeral Director: Afte bleted filled in by the fun Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hoi **To the Fune** completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29b. Signature and title of certifier

1~DIZEL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001

MD

South

29d. Date signed (Month, Day, Year)

St Baltimere MD 21225

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36686 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Year Emma V. Danner 1:02 ovember Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Hospita Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Months Hours Min. 217-20-4510 Maryland 86 Yrs. 1924 Director Usual Residence of Decedent ural", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MDBaltimore 1 Yes 2 □ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21229 556 Lucia Ave. USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 and 2 should be filed within 72 hours aft of Health and Mental Hygiene. if item 27 is marked other than "natural", other traumatic event, the Medical Exal. 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 ▼ Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Clerk Grocery Store Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Charles G. Rohrer Catherine Swink 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30 Bourbon Ct., Parkville, MD 21234 Virginia C. Smith (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗵 Burial 2 🗆 Cremation 3 🗆 Removal from State Loudon Park Cemetery [11/22/10 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lio 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 26a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Arterioscleration disease or condition resulting in death) Known a. Due to (or a a consequence of) Medical Examiner Ecquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) The law requires that the death certificate be executed and -tran resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Dav Year Pregnant at time of death 1 Yes 2 No 9 Unknown 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate ZNo Yes the Hospital or Attending Physician: 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Hospital မှ ER/Outpatient 3 DOA 4 Nursing Home 1 Inpatient 2 5 Residence After this 27. Manner of Dea h 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one Signature and title of certifier 29d. Date signed (Month. Dav. Year) wom 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Agnes 32. Registrur's Signature

✓ DHMH 17 Rev 7/2009

State Registrar

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State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ thu Month 2010 1015 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Worcest erlik rka . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 Maryland 8. Date of Birth **Funeral** Hours Jan 23, 216-68-3335 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Maryland 1 4 1 Baltimore Anne Arundel 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with:

Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a i any injury or other traumatic event, the Medical Examiner must be once. Funeral 118 Camrose Avenue 21225 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🖾 No Black White etc. 1 Never Married 2 Married δ 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Divorced 4 Divorced 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Housewife & Mother Homemaker Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ August Weinhold Dorothy Reichert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nolan R. Dove, Jr. (Son) 11311 Gum Point Road, Berlin, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Bayview Crematory, Inc. 1 Burial 2 X Cremation 3 Removal from State 11/19/2010 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Kevin E Ecker 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 130 East Fort Avenue, Baltimore, Maryland 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician Medical resulting in death) or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or). attending physician and for use as the burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day Year signed by the a d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2: 2 After this certification of the section of the sect 25. Was case referred to medical examiner? **Division of Vital** 26. Place of Death (Check only one) Be 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 7. Mapner of Death Certificate: 28b. Time of 28c. Injury at 🖺 Natural 5 \square Pending work? 2 🗌 No Accident Investigation within 24 hours after death

To the Funeral Director: completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 'Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioners To the pest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 [Name and address of person who completed cause of death (Item 23a) (Type, Print) State 3 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 Bailey Ellis Nov. 11:35 pM Jean Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Arnold Anne Arundel Future Care Social Security Numb If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Yean . 8 Days 1 M 2 F 577-32-5874 1928 Director Washington DC 82 Jan. Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel 1 Yes 2 V No Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21409 1506 Chester Town Circle United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married ð Yes 2X No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2X No Specify Specify: Completed 3 X Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 7; ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Realtor Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Edwin Allen Bailey Dorothy Evelyn Bowen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Summers / Daughter 1506 Chester Town Circle, Annapolis, MD 21409 20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory Inc.

Date
20c. Location - City or Town, State
11/23/2010

Baltimore, Maryland 20a. Method of Disposition permit. Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License Alyson Taylor 22. Name and Address of Facility Cremation Society of Maryland Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) cause. Enter Underlying attending physician and for use as the burial-transit The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 1 Live Birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown in the past 12 months? page 2 should be detached for Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate Yes 1 Tyes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica To the Funeral Director: After this certific completed filled in by the funeral director, æ 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred M Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 2 ☐ Acciden
3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License number of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 11 2010 6:15 AM M Medical Deborah Fern Ey 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fallston Harford <u>2904 Winchester Way</u> 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Days Hours Min. **Director** 212**-**60-7093 04/12/1952 Maryland Usual Residence of Decedent f show 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 ☐ Yes 2 😿 No MD Harford Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral or items 23a U.S.A. 2904 Winchester Way 21047 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 XNo If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 <u>Dental Assistant</u> Dentist Office Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Walter William Brolle Phyllis Holtgreve 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 2904 Winchester Way - Fallston, Maryland 21047 Robin Ey (husband) other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Highview Memorial Gdns.11/24/2010 Fallston, Maryland Signature of Funeral Service License 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. ٥ <u> 11750 Belair Road - Kingsville, Maryland</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician PANCREAT - NEUROENDOCRINE CANCIL disease or condition resulting in death) JC Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury Disc to for as a nonsequence off signed by the attending physician and d be detached for use as the burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Dav Yea 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown completed filled in by the funeral director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 🗆 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b, Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No injury Natural 5 Pending ☐ Accident Investigation s after death Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

3

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

2 3 2010

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PHELEPNEWTPUNIN

29c. License number

THOUD ROAD

00058475

BRL

29d. Date signed (Month, Day, Year)

NOVIEMBIEM 22

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Ma	aryland		rtment of H tificate of D		Mental Hy	giene Reg. No.	2 11 11	36690
	Physicia	ın/	1. Decedent's Name (First, Middle, Last,				"		2. Date of De	eath Dav	/ Year	3. Time of Death
	Medic Examin	cat	BRENDA OLIVIA EA 4a. Facility Name (if not institution, give s		<u>.</u>	1	4b. City, Town, or	Location of Death	11/17	/2010	O County of Dear	1714 M
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	Funeral Director		5. Social Security Number 6. Sec. 1 220–50–8721	M 2 10 F	(In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bii (Month, Da	v. Year)	Co	thplace (State or Foreign untry)
-			Usual Residence of Decedent		62				3/21/1	948	l Was	hington, DC
	ryland I-f sho ied at	cto	10a. State 10b. County			Town or Loc						10d. Inside City Limits 1 X Yes 2 No
	he Ma or 28s	Direction 1	DC 10e. Street and Number		W	ashing	10f. Zip Code			10a. Citi	zen of What Co	
	s 23a ust be	Funeral Director	201 58th Street NE	# 245			2001	9			USA	,
	r item iner m		11. Marital Status	12. Was Decedent Ev Armed Forces?		13. W	as Decedent of His Yes, specify Cubar	spanic Origin? (Sr	ecify Yes or No- Rican, etc.)	.	14. Race - Ame Black, Whit	
0000	safter ral", o Exam	ed by	1 ☐ Never Married 2 ☐ Married 3 🏝 Widowed 4 ☐ Divorced	1 Yes 2 X If Yes, Give Year or Dates.	No	1	☐ Yes 2🛣 No	Specify:		5	Specify: B1	
<u>ဂ</u>	2 hour	Completed	15. Decedent's Ed (Specify only highest grad			(Give ki	ent's Usual Occupa	ition uring most of work	king	16b. Kir	nd of Business	Industry
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yland	filed v al Hyg d othe event,	Be	17. Father's Name (First, Middle, Last)			NULSI	ing	18. Mother's Nan	ne (First, Middle			
<u>Ş</u>	uld be d Ment marke natic e	욘	James Edward Bank						rta Dral			
Ma	12 sho lith and 27 is i		19a. Informant's Name/Relationship (Typ. Tyra Earle / Daugl		Ť		Address (Street a Half Str					ŕ
ore,	of Hee		20a. Method of Disposition 1 Burial 2 Koremation 3		20b. Plac	ce of Dispos	ition (Name of atory or other place		Date	_	cation - City or	
Daitimo	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. The Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other (Specify,		1	rdale	Park	11/2				Maryland
Da	permit Depar Impor any ir	ļ	21. Signature of Funeral Service Licens	Taxo Mo	ors	^{22.} 55	Name and Address					A. Land 20747
			23a. Part 1. Enter the disease, or compl shock, or heart failure. List only on	lications that caused	the death. I						., 11d1 y 1	Approximate
P	h sician/	3)	Immediate Cause (Final disease or condition			VE	CARSION	/ASGULA	e DISE	:452	-	interval Between Onset and Death
7	Medical Examiner		resulting in death)	Due to (or as a								
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to (or as a	consequer	ice oi).						
	and -transif	Examiner	Cause (Disease or linjury that initiated events resulting in death) Last	c	consequer	nce of						
5	cate be executed physician and the burial-transi	edical E	resulting in death) East	4	oonocquoi	100 01).						
00/0	ath certificate be executed attending physician and for use as the burial-transit	146	IF FEMALE:	1.								
o Xoo	or the Hospital or Attending Physician; The law requires that the death certhic within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	sician/N	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome o 1 Live Birth 2 4 Pregnant at	of pregnance Fetal d		Ectopic pregnancy Other (specify)	1		2	23d. Date of de Month	livery Day Year
Ď :	the dea	Physic	1 Yes 2 No 9 Unk <i>n</i> own	9 Unknown	time of dea		Other (specify)					
ָר ה	is that igned to be deta	by	Part II. Other significant conditions con	ntributing to death bu	ıt not result	ing in the un	derlying cause give	en in Part I.				the cause of death?
ecords,	require been si	eted										robably 4 Unknown
2	e has l age 2 s	Completed								psy ormed?	prior to death?	topsy findings available completion of cause of
.	nysician; The Jar his certificate ha I director, page 2	Be C	25. Was case referred to medical examiner?		_	-	26. Pla	ce of Death (Chec		2 No	1 L Yes	s 2 🗆 No
֓֞֞֞֓֞֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֡֓֡֓֡֓֓֓֡֓֡֓֡֡֡֡֡֡	Pnysic this ce al dire	은	1 Yes 2 No	lospital:		3/Outpatient		4 ☐ Nursing H	ome 5 🗆 Resi			ify)
	tth. :: After e funer	cate	1. Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day,		injury	28c. Injury work? M 1 🗆		28d. Describe l	now injury	occurred	
	r Atter ter des irector by the	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury		e, farm, stree	et, factory, office		28f. Location (Number or Ru	ral Route Number,
בֿ בֿ	pital o burs af eral Di filled ir		200 Cartifier 1 2 Cartifician Plant	40				determination of	(t)			
	n 24 hr	Medical	29a. Certifier 1 Certifying Physi (Check 2 Medical Examin only one) 3 Certifying Nurse	er: On the basis of exa	amination a	nd/or investig	gation, in my opinior	n, death occurred a	at the time, date	and place,	and due to the	cause(s) and manner stated.
,	vithii To th	_	29b. Signature and title of certifier	\$)		29c. License	number			e signed (Monti	n, Day, Year)
			20 Name and address	Mand) / T		528		11/	17/201	0
			30. Name and address of person who co				1 Drive (Cheverly	, Maryla	and 2	0785	
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar					<u>-</u>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND #6 REP RENGOOD 11/139/10 months of Health and Mental Hydiene

			1 - State or Maryland / De Registrar	partment of Health and Iv ertificate of Death	, ,		691			
	Physicia		1. Degedent's Name (First, Middle, Last) VACKIE EdwARDS		2. Date of Death	Day Year	e of Death			
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	7.00 [4c. County of Death				
ممس	Funeral	-	Seasons Hospice 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Randallstown (if Under 1 Year I f Under 24 Hrs.	8. Date of Birth	Baltimore 9. Birthplace (State	te or Forei a n			
	Director		216-56-8758		(Month, Day, Yea Jan, 5, 1	953 N.C.				
	land show dat	tor	10a. State 10b. County 10c. City, Town or			10d. Inside	e City Limits			
	r 28a-1 notifie	Director	MD Balt.	imore	La	A	Yes 2 No			
	with th	Funeral I	2201 Ruskin Ave.	21217	10g.	Citizen of What Country? USA				
	s filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at.		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No	3. Was Decedent of Hispanic Origin? (Spel If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.	,			
21215-0036	irs aftei iral", o i Exam	Completed by	1 Never Married 2 Married 3 Widowed 4 Divorced 1 Yes 2 No If Yes, Give Year or Dates.	1 ☐ Yes 2 ☐ No Specify:		Specify: Black				
- - -	72 hou n "natu Aedica	nplet	(Specify only highest grade completed) (Gir	cedent's Usual Occupation ve kind of work done during most of workir . DO NOT use retired)	ng 16t	b. Kind of Business Industry				
212	within ygiene.	e Cor	Elementary/Seconday (0-12) College (1-4 or 5+)	borer	1	Moving Co.				
Maryland		To Be	17. Father's Name (First, Middle, Last)		(First, Middle, Maid	·				
ary	should by and Mer is marke aumatic		Clarence L. Edwards 19a. Informant's Name/Relationship (Type, Print) 19b. Ma	ailing Address (Street and Number or Rural		or Town, State, Zip Code)				
	1 and 2 s if Health item 27 other tra		Danielle Williams (daughter) 20a. Method of Disposition 20b. Place of Dis	2201 Ruskin Ave						
Baltimore,			1 Ruriel 3 Cramation 3 Removal from State of Cemetery, Co.	rematory or other place) NOV P Ount Crematory	• 1	altimore,Md.	•			
Salti	permit. Page Department of Important: If any injury or once.	3	21. Specture of Funeral Service Licensee	22 Name and Address of Facility Calvin B. Scrug	gs Fune:	ral Home				
_	TO = # 0	- 5	23a. Part 1. Enter the disease, or complications that caused the death. Do not e	1412 E. Preston	St Ba	lto, Md 2121 Approxir				
7	hysician/	8 19	shock, or heart failure. List only one cause on each line.	en Cer		Interval I Onset ar	Between			
	Medical Examiner		resulting in death) a. Due to (or as a cursequence of):							
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):	b. Due to (or as a consequence of):						
	executed an and rial-transit	Examiner								
Ş	ficate be executed g physician and is the burlal-transit	ledical E	resulting in death) Last Due to (or as a consequence of): d.							
09/89	irtificate ling phy e as th	/Med	IF FEMALE:							
ROX	eath ce attenc	Physician/N		B		23d. Date of delivery Month Day	Year			
п	at the d d by the etached	Phys	9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the	a underlying cause given in Part I	OO- Didashara		-6-1-11-0			
Դ.	uires tha signed Id be d	d by	Take in Suiter Significant Contributing to death but not resulting in the	s underlying cause given in r arc i.		co use contribute to the cause of 2 No 3 Probably 4				
Vital Records,	aw requasi beer 2 shou	Completed			24a. Was an autopsy	24b. Were autopsy finding prior to completion of	gs available			
Ž	r; The la icate ha r, page				performed	? death?				
VIta	ysiciar is certif directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	26. Place of Death (Check		6 Cother (Specify)	9			
101	ling Ph		27. Manner of Death 1 Natural 5 Pending 28a. Date of injury (Month, Day, Year) 28b. Time injury	of 28c. Injury at 2 work?	28d. Describe how in					
DIVISION	Attence or death ector; yet the	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined determined	M 1 ☐ Yes 2 ☐ No street, factory, office		and Number or Rural Route Nu	ımber,			
≥	oital or ours afte oral Dir illed in		building, etc. (specify)		City or Town, St		5			
	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. Within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check Only one) 1 Certifying Physician: To the best of my knowledge, deat Check Only one) 1 Certifying Nurse Practioner: To the best of my knowledge	estigation, in my opinion, death occurred at	the time, date and pla	ace, and due to the cause(s) and	manner stated.			
	To the Complete	-	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)				
			30. Name and address of person who completed cause of death (Item 23a) (Type	Print) 1	1 1	n 17,201	2/06)			
			MAROLD BOB 6934	1 Hrindin	3/216.	Sniko N =	2106			
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature	A CONTRACTOR OF THE PARTY OF TH						

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Please	Type or Prin				k. Ensure A Health and N	-		Legible.	
	-	For State Registrar		Otate of Wie	ii yiai N		ertificate of			Reg. No	010	36692
Physicia Medic		1. Decedent's Name James	e (First, Middle, La:	st)			Emmeri	ch	2. Date of Dea	16 16	ž̃ť1(3. Time of Death 02;00 p M
Examin		4a. Facility Name (if Union Ho		estreet and number)			4b. City, Town, 6	or Location of Death		^{4c. C} Cec	County of Death	
Funeral Director		5. Social Security Nu 220-30-57	752 1	Sex 7. Age XIM 2 □ F	(In yrs. Ia	st birthday Yrs.	Months Days		8. Date of Birt (Month, Day 09/23/			nplace (State or Foreign ntry)
and show	ō	Usual Residence of 10a. State	Decedent 10b. County		10c. City	, Town or l	ocation					10d. Inside City Limits
e Mary r 28a-f notifie	Sirec	MD 10e. Street and Num	Cecil		Con	owing	0 10f. Zip Code			10 000	())() -1 ()	1 Yes 2 X No
with th	Funeral Director	1670 Libe		e Road			21918			-	en of What Cou	intry?
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 □ Never Marri	ed 2 Married	12. Was Decedent E Armed Forces? 1 X Yes 2			. Was Decedent of If Yes, specify Cub	Hispanic Origin? (Spoan, Mexican, Puerto	ecify Yes or No- Rican, etc.)		4. Race - Ameri Black, White,	, etc.
hours a natural lical Ex	leted	3 Widowed	15. Decedent's E	Year or Dates. Education	962-	16a. Dec	edent's Usual Occu	pation			wn id of Business Ir	ite ndustry
thin 72 ne. than "r	Completed	Elementary/Seco	cify only highest gr onday (0-12)	rade completed) College (1-4 or 5	+)	life.	e kind of work done DO NOT use retired tronic Te		king	Fle	ctrical	
filed wil al Hygie I other vent, tl	Be	12 17. Father's Name (F	First, Middle, Last)			LICC	, ci olite it	18. Mother's Nan	ne (First, Middle,			
uld be d Menta marked natic e	2	James		_udwig	Emm	Т.	ı, Sr.	Ellen				Thorpe
d 2 sho alth and 127 is 1 er traur		19a. Informant's Na		, Daughter				t and Number or Rui WS Lane,				
ge 1 and to fit of He if item or other		20a. Method of Disp	osition	Removal from State	C	lace of Dis emetery, cr	position (Name of ematory or other pla	ace)	Date	20c. Loc	cation - City or 1	Town, State
nit. Pag artmen oortant: injury		4 Donation 21. Signature of Fur	5 Other (Spec	-	Bal		re Cemete 22. Name and Addr	ry 11/1	9/2010 Leonard		imore, luck. In	
permi Depar Impo any ir		▶ Oles	maragi	Blow				ord Road,	Baltimo	ore,		
Physician/ , Medical Examiner	J.	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, If say, healing to immediate.										
cate be executed physician and the burial-transit	dical Examiner	The family, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									Weeks	
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medical	IF FEMALE; 23b. Was decedent in the past 12 i 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 🗀 Feta	l death	B	ncy		2	3d. Date of deli Month	very Day Year
uires that the signed by the detail	þ	Part II. Other signif	ficant conditions	contributing to death b	ut not res	ulting in th	e underlying cause (given in Part I.	23e. Did to			the cause of death?
The law requate has been page 2 shou	Completed								24a. Was auto perfo 1 \square Yes		prior to death?	opsy findings available completion of cause of
sician: certific irector,	To Be	25. Was case referrence examiner?	ed to medical	Hospital:	ant 2 🗆	EB/Outpat		Place of Death (Che		dana - 6	Other (See)	
nding Phy ath. r: After this ie funeral d	Certificate: T	27. Manner of Death 1 Natural 2 Accident	h 5 Pending Investigation	28a. Date of inju (Month, Day	ry	28b. Time injun	of 28c. Inj		dome 5 Residence 1			7/)
tal or Atters after de al Directo ed in by the		3 Sulcide 4 Homicide	6 Could not determined				street, factory, office		28f. Location (\$ City or Tov		Number or Rur	al Route Number,
the Hospi nin 24 hou the Funer npleted fill	Medical	(Check 2 only one) 3	Medical Exar	ysician: To the best of niner: On the basis of e rse Practioner: To the	xaminatio	n and/or inv	estigation, in my opi e, death occurred at	nion, death occurred the time, date and pla	at the time, date a	and place,	and due to the o	cause(s) and manner stated.
To To Con		29b. Signature and	title of certifier	lone	حا	2		8347		NO Date	e signed (Month VEML), Day, Year) DEV 18, 2010
0.		DR. EL	IZABE	TH LOWE	= 11	11 4	High	Street	- Sult	Ea	63 EII	DEV 18,2010 Kton MD 2192
Sta Registr		31. Date filed (Mont	3 2010	32. Registry	4	arks	_					

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		1	For State Registrar	State of Maryla		artment o				giene Reg. No 2	10	36693
ı	Physicia Medic		1. Decedent's Name (First, Middle, Last)	rlich					2. Date of Dea Month		2 Year	3. Time of Death
الم	Examin	er		eet and number)		,	vn, or Location				74.00	
	Funeral Director		5. Social Security Number 215-07-2641 Usual Residence of Decedent	7. Age (In yrs. 91	/ast birthday) Yrs.	Months D	Year If Und	der 24 Hrs. s Min.	8. Date of Birth		9. Birthpi Count	lace (State or Foreign MD
	laryland 3a-f show üffed at	ector	10a. State 10b. County MD BALTIMOI		ity, Town or Lo						10	0d. Inside City Limits 1 ☐ Yes 2 🙀 No
	with the N 23a or 21 ust be not	Funeral Director	10e. Street and Number 4730 ATRIUM COURT			10f. Zip Co	ode			10g. Citizen of USA	What Count	try?
980	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	<u>ج</u>		2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.		Was Deceden if Yes, specify			cify Yes or No- Rican, etc.)		ce - America ck, White, e	
21215-0036	within 72 hou glene. er than "natu , the Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Seconday (0-12)		(Give	dent's Usual C kind of work o O NOT use re MEMAKE	done during n tired)	nost of worki	ng	16b. Kind of B		lustry
Maryland 2	should be filed within 72 and Mental Hyglene. is marked other than ' aumatic event, the Me	To Be	17. Father's Name (First, Middle, Last) SAMUEL	SIBEI				other's Name	e (First, Middle,	Maiden Surnam	e)	CAPLAN
	1 and 2 shoul of Health and I fitem 27 is m: r other traums		19a. Informant's Name/Relationship (<i>Type</i> ROZ EHRLICH/DAUGH						l Route Numbe LTIMORI	r, City or Town,	State, Zip C 21209	ode)
Baltimore,	Page 1 ar nent of He ant: If iten ıry or oth		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Ro 4 □ Donation 5 □ Other (Specify)	emoval from State	Place of Dispo cemetery, crea	matory or othe	er place)		Date . / 2010	20c. Location	-	wn, State
Balti	permit. Page 1 Department of Important: If i any injury or once.		21. Signature of Funeral Service Licensee		2	2. Name and	Address of Fa	cility SC	LEVI	NSON & I PIKESVII		
	Physician/		23a. Part 1 ther the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	cause on each line.	7		f dying, such	as cardiac o	or respiratory an	rest,		Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death) Sequentially list conditions, b.	Due to (or as a cons	quence of):	rtery	dis	serisc				
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medical Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	Due to (or as a conse			W					
68760	rtificate b ling physi e as the b	/Medic	IF FEMALE:	c. If yes, outcome of preg	nancy							
. Box 6	Attending Physician: The law requires that the death certificate be executed r death. setor. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	nysician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🔯 No 9 ☐ Unknown	1 Live Birth 2 Fe 4 Pregnant at time c g Unknown	etal death 3	Ectopic pre					ate of delive onth	Day Year
ls, P.O.	uires that the signed by a signed by a lid be deta	ed by P	Part II. Other significant conditions con	tributing to death but not r	resulting in the	underlying car	use given in F	Part I.				ne cause of death?
Division of Vital Records,	The law req ate has bee page 2 sho	Complet	hyperlipideni suggesting isc severe valvula	havic her	diseas	ses<					Were autoprior to codeath?	psy findings available mpletion of cause of 2 🗷 No
Vital	ysician: is certific director,	To Be (25. Was case referred to medical	ospital:			26. Place of	Death (Chec		dence 6 🗆 Oti	ner (Specify	<i>'</i>)
on of	ending Pheath.	Certificate:	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident Investigation 3 □ Suicide 6 □ Could not be	28a. Date of injury (Month, Day, Year)	28b. Time o injury	М	v. Injury at work?	2 🗌 No		now injury occur		
Divisi	ital or Att urs after d ral Direct		4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	cify)				City or To			
	the Hosp hin 24 ho the Fune npleted fi	Medical	(Check 2 Medical Examine only one) 3 Certifying Nurse	cian: To the best of my known: On the basis of examina Practioner: To the best of	tion and/or inve my knowledge	stigation, in my death occurre	y opinion, dea d at the time,	th occurred a date and pla	t the time, date ce, and due to th	and place, and d ne cause(s) and n	ue to the ca nanner as st	use(s) and manner stated. ated.
	5 With		29b. Signature and title of certifier			D 29c. 1	icense numb	8783		29d. Date sign	2010	Day, rear)
10	7 °.		30. Name and address of person who co	mpleted cause of death (It	em 23a) (Type,	Print)	+ Hos	pital	ER-7			
1	Sta Begist	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sig	pature 6	Kel						

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andon James		State of Marylana / Boparane	ent of Health ar ate of Death	nd Mental Hy	ygiene		2010	36694
		Registrar	ate of Death		2. Date of Dea	Reg. No.		To
Physicia dical Exami		1. Decedent's Name (First, Middle,Last) Brandon J. Erbe			Month	Day	Year	3. Time of Death 1752 hrs
J. Gar Exami		4a. Facility Name (if not institution, give street and number)	4b. City. Town. o	or Location of Death	Novembe		County of Death	
		208 12th Avenue	Brooklyn	2000110110120011			Anne Arundel	,
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birth	nday) If Under 1 Ye	ar If Under 24Hrs.	8. Date of B	irth(MM/	DD/YYYY) 9. Bir	thplace (State or
Director		218 98 9440 1 NM 2 F 28	Yrs. Months Da		-		Foreig	
		Usual Residence of Decedent	115.		007			
any		10a. State 10b. County 10c. City, Town of	or Location					10d. Inside City Limits
nd show	Ę	Maryland Anne Arundel Bro	oklyn Park					1 Yes 2 No
Sa-ra	Director	10e. Street and Number	10f. Zip Code			10g. Citi:	zen of What Cou	ntry?
the M	Ö	109 - 5th Avenue	21:	225	- 1		U.S.A	•
with with se no	ā	11. Manital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of H			0-	14. Race - Amer	can Indian, Black,
leath r iten	Funeral	1 Never Married 2 Married Armed Forces?	If Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)		White, etc.	
after after ner n	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 X N	o specify:			Specify: WI	nite
natur xam			Decedent's Usual Occup- luring most of working lif			16b. F	Gind of Business/	ndustry
6 n 72 h	lete	Elementary/Secondary (0-12) College (1-4 or 5+) 2 years			edj	11.	A	01-+1
5-0036 ed within 7/ tygiene. other than	Completed		Shift Man					or Clothing
filed Hyg		17. Father's Name (First, Middle, Last) Ronald V. Erbe		18.Mother's Name	(First, Middle, ene Jaп		Surname)	
ID 21215-0036 should be filed within 72 hours after death with the Maryland and Montal Hygiewith and Montal Hygiewith "matural", or items 23a or 28a-f sho natic event, the Medical Examiner must be notified at once.	To Be		. Mailing Address (Stre				ity or Town State	Zin Code)
MD 2 nd 2 shoul alth and N m 27 is m	-		9 - 5th Ave					yland 21225
e, MI and 2 : Fealth a item 27 traum		20a_Method of Disposition 20b. Place of	f Disposition (Name of co		Date		Location - City or	
OF ges 1 it of 1 it af 1		Clop	ory or other place) Haven Mem.	Park 11/	20/2010		on Dunni	a Maryland
Baltimore, bermit Pages 1 ar Department of Her Important: If ite		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	22. Name and Address					
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum		0. 7 //1-			nce rum av Balt	nera. Limo	1 Servic re. Marv	e, P.A. land 21225
Physician		23s/Part I. Enter the disease, or complications that caused the death. Do not						Approximate Interval
/Medical		failure. List only one-cause on each line. Immediate Cause (Final disease a. <u>Oxycodone Intoxic</u> a	ation and C	oooino Na	•			Between Onset and Death
Examiner		or condition resulting in death) Due to (or as a consequence of):	acion and c	ocarne os	Е.			
		Sequentially list conditions, b.						
	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause						
	cam	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		 -				-
executed an and al - transit		d						
ਿਲ ਲਿ	dical	X unpended □ AMENDED 23a,27,28a-	f nerMF CQ1	0 12/3/20	110 119			
760, icate be g physicia the buris	sician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy	1,pe11111,091		710,WD	230	d. Date of delivery	,
OX 687 eath certific attending p	ian	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 4 Pregnant at time of death	=	Ectopic pregna	ncy		Month [Day Year
OX eath c	/sic	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)					
D. B trthe de by the	Phys	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause	given in Part I.	23e. Did 1	tobacco	use contribute to	the cause of death?
res that signed be deta	l by				1 🗌 Ye	es 2 🗸	No 3 Prob	ably 4 Unknown
ds, equir	Completed				24a. Was			topsy findings available
COI law 1 las t e 2 sh	npl					ormed?	death?	completion of cause of
tal Rection: The certificate ector, page			20.5		1 ✓ Yes	2N	0 1 🗸 Ye	es 2 No
ital sician is cert irecto	Be	25. Was case referred to medical examiner? Hospital: Inpatient 2 ER/Ou	utpatient 3 DOA	of Death (Check of Other)	nly one) g Home 5	Pacida	nce 6 🗸 Other	·· Canaa
n of V ing Phys After thi funeral d	: To	Tes Z No		ury at Work?	28d. Describe			: Scene
on on or or or or or or or or or or or or or	Certification:	(Month, Day, Year)	- 10	Yes 2 No	Unknow		,	
iSiC Atte er dea recto	icat	2 Accident Investigation 28e Place of Injury - At home fai		building, etc.	28f. Location	Street a	nd Number or Ru	ral Route Number, City
Div pital or ours afte reral Die	ertif	3 Suicide 6 A Could not be determined Specific Residence	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		or Town, Brookly		08 12 t h MD	ral Route Number, City Avenue
Hospi 4 hou Funer ely fil		29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time.					ed.
Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be within 24 hours after death. To the Function: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical	one) 2 Medical Examiner:On the basis of examination and/or in						
F is F	Me	29b. Signature and title of certifier	29c. Licen	se number		29d. [Date signed (Mo	nth, Day, Year)
		Mlen Grassell MD	O.C	.M.E.		Nov	ember 17, 20	010
(10)		30. Name and address of person who completed cause of death (Item 23a)				1	,	
		Melissa Brassell, MD Assistant Medical Examiner	111 Penn Street,	Baltimore, MD	21201			
S	tate	31. Date filed (Month, Day Year). 32 Register's Signature	1					

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			101	nt of Health and Mental Hygiene te of Death Reg No 2010 36695
			Registrar 1. Decedent's Name (First, Middle, Last)	Pe of Death Reg. No. 1 3 5 9 3 2. Date of Death 3. Time of Death
	Physicia		Calvin Clifford Fraley	November 17 2510 0257
	Medic Examin			, Town, or Location of Death 4c. County of Death
			Washington County Hospital Had	gerstown Washington
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under	or 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Hours Min. (Month, Day, Year) Country)
	Director		236-46-2136 TIM M 2 LIF 77 Yrs. World Street 77 Yrs. World St	Days Hours Min. (Month, Day, Year) Country) 12/07/1932 West Virginia
	and show	ō	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
	Maryl 28a-f otiffed	irec	MD Washington Hagerstown	1 □ Yes 2 🖾 No
	h the	al D	10e. Street and Number 10f. Zip	p Code 10g. Citizen of What Country?
	ms 2x must	Funeral Director		1740 U.S.A.
·0	or ite			dent of Hispanic Origin? (Specify Yes or No- cify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
9	rs afte iral", Exan	Completed by	3 ☐ Widowed 4 🗷 Divorced If Yes, Give Year or Dates.	2 ☒ No Specify: Specify: White
2-0	2 hou "natu adical	plet	15. Decedent's Education 16a. Decedent's Usus (Specify only highest grade completed) (Give kind of wo	ual Occupation 16b. Kind of Business Industry
121	thin 7 ene. than than	yom	Elementary/Seconday (0-12) College (1-4 or 5+) life. DO NOT use	e retired)
d 2	flied within 72 hours after death with the Maryland all Hygiens all Hygiens do ther than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at	o l	9 Busines 17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname) Unknown
a	ould be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	욘	Melvin Fraley	
Baltimore, Maryland 21215-0036	12 should be file lith and Mental H 27 is marked o r traumatic eve			is (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Σ.	nd 2 s ealth m 27 her tra			otty Pine Dr., Hagerstown, MD 21740
ore	Page 1 and 3 πent of Heall ant: If item 2 ury or other		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Nancemetery, crematory or or	other place)
턡	it. Pag rtmen rrtant: njury			egistry 11/23/2010 Hanover, Maryland
Ba	permit. Page Department Important: I any injury o			nd Address of Facility Anatomy Gifts Registry Connelley Dr., Ste. P, Hanover, MD 21076
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mod	de of dying, such as cardiac or respiratory arrest, Approximate
مر و	h sician/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	Interval Between Onset and Death
	Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	AHION THILLIAT
	Examiner	<u>.</u>	Sequentially list conditions, b.	31 F)
	sit sit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	
5	xecute n and al-tran	Еха	that initiated events c. resulting in death) Last Due to (or as a consequence of):	
00	ate be executed bhysician and the burial-transit	dical Examiner	d	
876	ificate ng phy as the	Med	IF FEMALE:	
89 ×	eath certificat attending ph for use as th	Physician/Me	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 \subseteq Live Birth 2 \subseteq Fetal death 3 \subseteq Ectopic	
Вох	e deat the at hed fo	ysic	1 Yes 2 No 4 Pregnant at time of death 5 Other (sc 9 Unknown 9 Unknown	Month Day Year
P.O.	requires that the de been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the underlying	cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
S,	ires th signe Id be	Completed by	SEVERE ANEMIA, DIFFUSE B	1 Yes 2 No 3 Probably 4 Unknown
ord	v requ	olete	LECTONIC SUSPICIOUS FOR MET	24a. Was an 24b. Were autopsy findings available
ဒ္ဓင	he lav te has age 2	mo	DEMENTIA CHE	autopsy prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No
a	ian: T ertifica etor, p	Be C	25. Was case referred to medical examiner?	26. Place of Death (Check only one)
=	Physician: The law I r this certificate has t rral director, page 2 s	은	1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 Do	
0	ding P	Certificate:	1 Natural 5 Pending (Month, Day, Year) injury	28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No
Siol	Attenc ctor: y the	rtific	2	
Division of Vital Records,	al or / s after il Dire		4 Homicide determined building, etc. (Specify)	City or Town, State)
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at (Check (Check 2 Medical Examiner: On the basis of examination and/or investigation, in	t the time, date and place, and due to the cause(s) and manner as stated. my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	thin 24 the F the F the F mplet	Me	only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occu	urred at the time, date and place, and due to the cause(s) and manner as stated.
	₽ ₹ ₽ 8		290. Agridue and the or gentler	c. License number 29d. Date signed (Month, Day, Year)
	d		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	00000027
	X		(n = 11).	antietam St., Hagerstown, MD 21740
	Stat		31. Date filed (Month, Day, Year) 32. Registrar's Signature	
	Registra	ar,	NOV 2 3 2010 Que 8. Janes	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 36696 State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death Rea. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** a^{M} Ferracci 19,2010 Louis Joseph November 0106 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico 31912 Melson Road Delmar If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1**X** M 2 □ F Months 212-42-0236 68 Director March 13, Maryland Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show Director MD Wicomico Delmar 1 ☐ Yes 2 ☑ No 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? 31912 Melson Road 21875 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🔼 No Specify: 2 Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 1 year Assembly Line Worker General Motors permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygle Important: If Item 27 is marked other ti any Injury or other traumatic event, In. 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Ferracci Jeanette DiNenna ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife 31912 Melson Road, Delmar, Maryland 21875 Laurel Ferracci 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State November 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 23, 2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part 1. Enter the disea é, o shock, or heart failure. Lis complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Jonera tic Carcinoma moutas disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter crucinying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No for Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 🗆 No 1 □Yes 2 □√No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 A Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

Box 68760. P.0. of Vital Records, The Physician: Division Hospital or Attending within 24 hours after death To the Funeral Director: the

Maryland 21215-0036

Baltimore,

State Registrar

DHMH 17 Rev 1/2001

32. Registrar's Signature 31. Date filed (Month, Day, Year) 2 3 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9 TIGNAS

100 East ConvII street Salisbury.

20014314

Mrs.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36697 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Genevieve S. Gaff 8:33 A^M November 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death N/A GoodSamaritan Nursing Home Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 - M 2 X) F Days Hours Min. Months 88 216-16-4848 Yrs Director November Maryland Usual Residence of Decedent r 28a-f show notified at 10b. County death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD N/ABaltimore 1 X Yes 2 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be r Funeral 1601 Ε. Belvedere Street 21239 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 9 þ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: White "natural", Specify: Completed 3 X Widowed 4 Divorced the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) 12 Doctor's Office Receptionist Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked off any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Schaffer Maude Worsdell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Gaff - Son 1544 William Street, Baltimore, MD 21230 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Most Holy Recemen 11/23/2010 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services - Parkville 8800 Harford Road, Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on or Attending Physician: The law requires that the death certificate be executed after death. physician and the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician hed for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Pregnant at time of death 9 Unknown sate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autons performe After this certificate | 2 No Yes 1 Yes To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred injury work?
1 Yes 2 No 5 Pending 2 Accident 3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. e cause(s) and manuer as 222/20/0

DHMH 17 Rev 7/2009

State Registrar death (Item 23a) (Type, Print)

d

32. Registrar's Signature

and address of person who completed cause of

doch

560

31. Date filed (Month, Day, Year)

			For State Registr <i>a</i> r	State of	f Marylan	-	artmen rtificat			and M	ental Hy	giene Reg. No. U	10	361	598
-	Physici	an	1. Decedent's Name (First, Middle								Date of De Month	Day	Year		e of Death
	/Medic			ick Graci							Youemb				44P M
	Examin	er	4a. Facility Name (If not institution	-					Location of	of Death		4c. Co	unty of Dea	th	
			5. Social Security Number	nd Medial (7. Age (In yrs.	last hirthday)	If Under		If Under	24 Hrs.	8. Date of Bir	rth	9 Bir	tholace (Sta	ite or Foreign
	Funeral Director		184-28-9968	1 M 2□ F	7. Age (myis.)	Yrs.	Months	Days	Hours	Min.	(Month, Da	a <i>y, Year)</i>	Co	untry) nnsylv	
			Usual Residence of Decedent		/3						JCC • 2.	1, 100	/ 101	IIISY I V	ania
	yland		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside	e City Limits
	a-fs	cto	WV Hamps	shire	I	Romney								1 🗆 Y	′es 2 X No
	or 28	Funeral Director	10e. Street and Number				10f. Zip	Code				10g. Citizer	of What Co	untry?	
	ath w	<u>ra</u>	HC65 Box 4927 1	Middlerid	ge Road				7-931			US			
	er des	au	11. Marital Status	Armed Fo	edent Ever in U. rces?	S. 13.	Was Deced If Yes, spec	lent of Hi lify Cuba	ispanic Ori n, Mexicar	igin? (Spe n, Puerto F	cify Yes or No Rican, etc.)	0- 14.	Race - Ame Black, White		١,
36	s afte	by F	1 ☐ Never Married 2 ☐ Marr 3 ☐ XWidowed 4 ☐ Divorced	If Yes, Giv	ve		1 □ Yes	2 X No	Specify:			Sp	ecify: Wh	ite	
5-0036	hour tural	be k	15. Deceden	Year or Di	ates:	16a. Dece	dent'e Heu	al Occup	ation			16h Kind	of Business	Industry	
15	in 72 n "na le fic	plet	(Specify only highe	st grade completed)		(Give	kind of wo	rk done d e retired	during mos	t of workin	g		or Dadiness.	maasii y	
2121	with yiene	Completed	Elementary/Secondary (0-12) 12th	College (1	-4or 5+)	1	ainte			_		Apar	tment	Compl	.ex
b	filed Il Hyg othe	Be C	17. Father's Name (First, Middle,	Last)					18. Mothe	er's Name	(First, Middle	e, Maiden Su	rname)		
<u>a</u>	uld be Aenta rked ric ev	10 B	Frederick J. (Gainor					Fa	у Но	ockenbe	erry			
Maryland	shot and N		19a. Informant's Name/Relations	hip (Type. Print)		19b. Mailir	ng Address	(Street	and Numb	er or Rura	l Route Numb	per, City or T	own, State, .	Zip Code)	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Medical Exaction of the matter and once.		Cheri Gainor/	Daughter			Redha			, Th	nurmont	t, MD	21788	3	
Baltimore,	es 1 of He if Item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	2 Demoval from	20b. F	Place of Dispo cemetery, crer	sition (Nar natory or o	ne of ther plac	e) ;	Da	ate	20c. Loca	ion - City or	Town, State	Э
Ĕ	Pag ment ant: I		4 Donation 5 DOther (S		Но	oly Tr					7/2010	For	d City	, PA	
3alt	permit Depart Import any In		21. Signature of Funeral Service	Licensee	1.	22	2. Name ar	d Addres	ss of Facili	by Dor	naldso	n Fune	ral Ho	ome, E	P.A.
	⊈O = @ O		- Jamile	AMOO!	M0110						e, Lau		MD 20	707	
0	Physician /Medical Examiner		23a. Part1 on er the disease, or show, or heart failure. List Immediate Couse (Final disease or condition resulting in death)	a. Isch		teart	Discontinuos			cardiac o	r respiratory a	arrest,			mate Between and Death
gar Bar		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	or as a conseq										
s (68760)	ertificate be executed ing physician and a as the burial-transit	ical	IF FEMALE:	d	(or as a conseq										
P,O. Box 68	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live I	come of pregna birth 2 Feta nant at time of coown	Ideath 3	☐ Ectopic p ☐ Other (sp		у			230	i. Date of de Month	Day	Year
	w requires that the d been signed by the should be detached	þ	Part II. Other significant condition	ons contributing to de	eath but not res	ulting in the u	nderlying c	ause give	en in Part I			tobacco use Yes 2□	,		of death?
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<u> </u>	siclan: The lav certificate has rector, page 2	ĕ									perf	ormed?	death? 1 ☐ Ye:	-	01 00000
/ita	ctor,	Be (25. Was case referred to medica examiner?						26. Place	e of Death	(Check only				
<u></u>	hysik his c		1 Yes 2 10 No		<u> </u>	ER/Outpatie	nt 3□D0	Oth	er: 4 🗆 N	ursing Hon	ne 5∐Res	sidence 6 [Other (Spe	ecify)	
Ē	aling Phys n. After this funeral dii	ü	27. Manner of Death 1 ☑ Natural 5 ☐ Pendir	28a. Date (Mon	of Injury th, Day, Year)	28b. Time o Injury		8c. Injur Worl			28d. Describe	how injury o	ccurred		
Division of Vital Records,	To the Hospital or Attending Physician: The lawithin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification: To	2 Accident investi 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place	of Injury - At he	ome, farm, str fy)	M reet, factory		Yes 2□		28f. Location City or To	(Street and I own, State)	Number or Fi	ural Route	Number,
_	Hospital	Medical Ce	(Check only 2 Medical	ng Physician: To the Examiner: On the b	asis of examina	owledge, deat ation and/or ir	th occurred	at the ti	me, date a	nd place, a	and due to the	e cause(s) a e, date and p	nd manner a	is stated.	se(s)
	thin 2	Med	one) 29b. Signature and title of certifie		ner stated.		291	Licens	e number			29d Date	signed (Mon	th Day Yea	ar)
	F 3 F 8		of white Un	di	MO				585	(12.5	5	11 11	8/10	_,, , , , ,	-
	_		30. Name and address of person	who completed assis	o of dooth /	n 22a\ /T		LI	00-	3 1200		1.10	0110		
-	12		LYO JA FILHES	R 22	Se of death (lief	M.C.		ilti	nose	Mr	21:	201			
	Sta	_	31. Date filed (Month, Day, Year)	32. F	Registrar's Signa	ature	4 4-1			115					
	Registr	ar	MIIV Z J ZUIU	Charren	1 100	Kar									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36699 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER 46. 2010 8:14 P M MICHAEL WILLIAM GUILTA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE BALTIMORE 7210 CONLEY ST . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. octonth, 924, 1934 1 😾 M 2 🗆 F 76 MD Director 219-30-4634 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No BALTIMORE BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21224 USA 7210 CONLEY ST 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces? Black, White, etc.
WHITE þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOUFF TRANSFER TERMINAL MANAGER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ ELIZABETH LAMP MICHAEL LAWRENCE GUILTA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7210 CONLEY ST BALTIMORE, MD 21224 HARRIET GUILTA-WIFE 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 🛛 Burial 2 🗆 Cremation 3 🗆 Removal from State OAKLAWN CEMETERY 11/20/10 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CHARLES S. ZEILER AND SON, INC nature of Funeral Service Licensee BALTIMORE, MD 21224 6224 EASTERN AVE Part 1 Enter the or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death List only one cause on each line Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of): Cause (Disease or iinjury the Hospital or Attending Physician; The law requires that the death certificate be executed Mel attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) Yes been signed by the sahould be detached 9 July 9 LINKnown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an cate has page 2 s autopsy performe certificate 2 N within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 PResidence 6 Other (Specify) Hospital: ဂ္ 2 1 No 1 Inpatient 2 ER/Outpatient 3 IDOA 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 2060

State Registrar 22

32. Registrar's Signature

13

1/260

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1. A. TORO201

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. ASTATE of Maryland & Department of Health and Mehital Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Hiller Physician/ Estha Month Day 2010 20 2005 Nov Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Catonsville Catonsville commons Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 💢 F 212.16.6525 Months 91 Month 221 1919 Country) MD Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral W. Franklin Street, Apt. 39 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Şeconday (0-12) College (1-4 or 5+) rederal 3rd gradu Gwernment Be permit. Page 1 and 2 should be filed in Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sadie Gray Joseph Gray 19a. Informant's Name/Relationship (Type, Print)

Penise Worfleet Valker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter) 3201 Carlswood Circle) Baltimore MD 21244 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Louton Park Cometen 2010 ll Baltmone, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Yalighn C. Greene Funeral Vauge 23a. Part 1. Enter the disease, or complications that caused shock, or heart ailure. List only one cause on each line disease, or complications that caused the death. Do not enter the mode of dying, slich as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Canca) Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 certificate has been signed by the attending pirector, page 2 should be detached for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month Year Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? Yes 2 No 1 ☐ Yes 2 ☐ No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural 1 Yes 2 🗌 No Accident Investigation 24 hours after deat Funeral Director; Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 037573 22, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Batte MD **7831** Z. Del 21207 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 36701 Vanessa Hicks 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ Month Day Year November 15, 2010 Vantessa Medical Examiner E. Hicks 1841 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deatl **Baltimore** 25323 Aisquith Street 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign **Funeral** Country) Months Hours Director Days 1947 214.50.2090 Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits MD ment of Health and Mental Hygiene. Iant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once. Baltimore Yes 2 No Pages 1 and 2 should be filed within 72 hours after death with the Maryland neut of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10e. Street and Numbe 10f, Zip Code 10g. Citizen of What Country isquith USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married 1 Yes 2 No Black 3 Widowed 4 Divorced If Yes, Give Year Yes 2 No specify: \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ltimore, MD 21215-0036 Raltinarre Citz Social Worker 12th grade Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edna Dukes Albert McNeill Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1 St Louis, MO 63118 Ronald D. Thomas 3628 Tennessee Avenue. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date crematory or other place) 1 Burial 2 Cremation 3 Removal from State AKESVITE MD Druid Lidge 4 Donation 5 Other Specify Vaughore Greene Funcial services 21. Signature of Funeral Service Licenses 728Liberty Road andallston disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. Between Onset and Medica Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED attending physician for use as the burial -Box 68760, IF FFMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Live birth Month Year ned by the attending detached for use as Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 V No 9 Unknown Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 歹 1 Yes 2 No 3 Probably 4 Vunknown Completed Records, page 2 should been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? ✔ Yes 2 No 1 🗸 Yes certificate 2 No 26.Place of Death (Check only one) 25. Was case referred to medical director of Vital Be examiner? Other: A Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 DOA Inpatient 2 this ဥ 1 Yes 2 No 27. Manner of Death After 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural Division within 24 hours after death.

To the Funeral Director: A completely filled in by the fu r death. 1 Yes 2 No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29h S and title of certifie OCME November 16, 2010

Registrar DHMH 17 Rev 1/2001

State

OCME 2006

Laron Locke MD.

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registra Signa

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Lewis Milton Hooper State of Maryland / Department of Health and Mental Hygiene 2010 36702 1- For State Certificate of Death Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Day November 20, 2010 **Medical Examiner** 1745 hrs Lewis Milton Hooper 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 7716 Edgewood Avenue Pasadena Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign **Funeral** Country) Director 241-34-7013 1 X M 2 F 81 March 18. 1929North Carolina Yrs Usual Residence of Deceden 10b. County Inv 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Marvland Anne Arundel Pasadena Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21122 USA 7716 Edgewood Avenue Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specity Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1X Yes If Yes, Give Year 46-46 3 X Widowed 4 Divorced 1 Yes 2 No specify: Specify: White ₫ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Montgomery Ward Engineer 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Jethro Hooper Sadie Aycock ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jethro Hooper, Son 5585 Linton Road Sykesville, Maryland 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 11/24/10 4 Donation 5 Other Specify. Glen Burnie, Maryland 22 Name and Address of Facility Home, 21. Signature of Funeral Service Licensee Thomas Gregor 301 Frederick Road Cátonsville, Maryland 21228 omai Part I. Enter the disease, or complication failure. List only one cause on each line ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval Between Onset and /Medical aHypertensive atheroslceortic cardiovascular disease Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed the attending physician and led for use as the burial - trans Physician/Medical X UNPENDED 3a,PII,27,per ME g909 11/30/10 TT Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. has been signed by 2 should be detach 23e. Did tobacco use contribute to the cause of death? ۾ Colon cancer 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? ✓ Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) ToBe examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 Other: Scene this 2 No 1 🗸 Yes After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 8c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 X Natural Director: d in by the f 1 Yes 2 No hours after death. Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 28f. Location (Street and Number or Rural Route Number, City 6 Could not be or Town, State) within 24 hours a To the Funeral I determined Homicide 29a. Certifier 1 __ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E November 21, 2010 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 22. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 5, 15 P_M 2. Date of Death Decedent's Name (First, Middle, Last) November Day 9 Physician/ atricia Medical a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Loch Kaven Community Living Center Baltimore N/A If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F Sept 4, Year 950 Alabama 438-86-6022 60 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location Director 1 X Yes 2 No Baltimore Maryland N/A 10e. Street and Number 10g. Citizen of What Country? Funeral 21206 USA 6056 Moravia Park Drive Apt.2B within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces? 1XXYes 2 ☐ If Yes, Give 2 No 1969 by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 1975 Completed 3 Divorced 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medicaal. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ashton Fitzgerald Etta Waldrip 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6056 Moravia Park Drive Apt.2B Baltimore, MD 21206 Patrick Haynie, Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/22/10 Metro Crematory Inc. Baltimore, Maryland Signature of Funeral Service License Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryl Maryland 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Rectal Onset and Death Immediate Cause (Final al 05 Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to or as a consequence of Examin Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death n signed by the a 2 🗌 No 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 4 Unknown cate has been sig page 2 should b 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy autope, performed 2 2 No this certificate 1 Yes 2 1 Yes director, 25. Was case referred medica Be 26. Place of Death (Check only one) examiner? 4 ☐ Nursing Home 5 ☐ Residence 6 Dother (Specify) H 05 P1 Ce 2 1 No Other: ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by the funeral 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After t ✓ Natural 5 Pending 1 ☐ Yes 2 ☐ No death. To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Bou aven

State Registrar T20192

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

32. Registrar's Signature

av

and

Wicks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 per me,g911,01/12/2011dhb Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year 10:05 PM JOH W HRASOWENSKI 7010 Novem Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE N/A HOPKINS BAYVIEW MEDICAL CENTER 8. Date of Birth (Month, Day, Scot 22 Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Min. 1 🕅 M 2 🗆 F 201-24-0892 Director 1931 Huntingdon, PA Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Parkville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21234 United States 2512 Michaels Lane 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black White etc. Completed by 1 Never Married 2 Married Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 → Widowed 4 □ Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore County School Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Frank Teodor Hrabowenski. Anna Z. Zanylo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1198 Zion Ridge Avenue Bellefonte, Pennsylvania 16823 Nicholas Hrabovenski (Brother) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite 1 Burial 2 Cremation 3 Removal from State November Oak Lawn Cemetery 4 Donation 5 Other (Specify) 20, 2010 Baltimore, Maryland Signature of Funeral Service License Name and Address of Facility Evans Funeral Chapel & Cremation Services—Parkville 8800 Harford Road Parkville, Marvland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Physician/ RESPIRATERY disease or condition 2 han Medical resulting in death) Examiner months Jacun Sequentially list conditions, CERTIFICATION APPROVED BY MEDICAL EXAMINER Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year 2 No 9 Unknown Unknown After this certificate has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autons performed? 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 17 No Other: 1 X Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work?
1 Yes 2 No 5 Pending death. ☐ Accident ☐ Suicide Investigation irector 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature and title of 29c. License number 29d, Date signed (Month, Day, Year) RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

ASYUL GOVIL

NOV

EASTERN AVENUE

BALTIMORE, MD

4940

M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 9:00 ₩ Loretta C. Hudson 2010 November Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death 2709 Waldor Drive Baltimore Parkville Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours (Month, Day, 1) March 27 216-24-5115 82 Director Maryland Usual Residence of Decedent or 28a-f show notified at 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. iftem 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD Parkville 1 ☐ Yes 2 🎇 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2709 Waldor Drive 21234 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black White etc. Completed by 1 Never Married 2X Married Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Telephone Company College (1-4 or 5+) Telephone Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Walter Brown Catherine Moylan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 2709 Waldor Drive, Parkville, MD 21234 Russell Hudson/ Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 Lemetery crematory or other place).

Meadowridge Cemetery Nov.

Meadowridge Cemetery Nov. permit. Page 1
Department of I
Important; If it
any injury or or ō ■ Burial 2 □ Cremation 3 □ Removal from State Elkridge, Marylam 4 Donation 5 Other (Specify) 22. Name and Address of Facility Evans Funeral 8800 Harford ture of Funeral Service Licenses Chapel & Cremation kville, MD Road, rt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician Medical resulting in death) Duy 1 (or as a consequence of): Examiner V-EAVI Sequentially list conditions Examine if any, leading to immediat cause. Enter Underlying been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 W Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page 2 autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🔀 No Other: မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No after death Director: A d in by the f Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after de To the Funeral Directo completed filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 3

State Registrar 29b. Signature and tit

(Month, Day, Year) V 2 3 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

29c. License number

D0037291

29d. Date signed (Month, Day, Year)

.206 Baltimore MD 21239

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nonth Year assandra lenderson PM m 2010 Medical Examiner ne (if not institution, give street and number) County of Death stown timore If Under 1 Year If Under 24 Hrs. Age (In vrs. Jast birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗷 Director or 28a-f shov 10b. County 10a State within 72 hours after death with the Maryland riem 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Me. "al Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ ☐ Yes 2 Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify: If Yes, Give Year or Dates. Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) be filed within 72 lental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Be Father's Name (First, Middle: Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F 2 permit. Page 1 and 2 should be Department of Health and Ment Important; If item 27 is marke any injury or other traumatic once. Rural Route Number, City or Town, State, Zip Code Mailing Address (Street and Number or 20a. Method of Disposition 20b. Place of Disposition (Name of Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lic 23a. Pat/1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock/or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final ridnes Physician hronic disease or condition resulting in death) Medical Examiner Immunude Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Die to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last been signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 2 JNO 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ erebovascule Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autons After this certificate 2 No Yes 1 Yes To the Funeral Director, After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 6 Dother (Specify) Hospital 2 № No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No Natural iniury 5 Pending Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral D Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Sigi 29d. Date signed (Month. Day, Year) 00053337 November 14 2010

State Registrar

DHMH 17 Rev 7/2009

Ane

Suite 203 Baltinume Milzizog

Smith

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

31. Date filed (Month, Day, Year

2835

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Hilliard Month Day 20th Year 2010 Richard 1:58 PM Novembe Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Medical Center Baltimore Baltimore 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year I If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**XX**M 2 □ F Hours May 3, 1936 74 Pennsylvania Director 159-30-1058 Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Harford Aberdeen 10g. Citizen of What Country? Funeral 208 Angus Drive 21001 **USA** within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. δ 1 Never Married 2 X Married Yes 2XXNo Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: White 3 Divorced 4 Divorced Completed Year or Dates. traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Sears Catalog Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve once. ပ Lela Louise Kerr Glenn Edward Hilliard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Hilliard (wife) 208 Angus Dr., Aberdeen, MD 21001 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Evans Funeral & Cremation 11/23 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Physician/ ST- Elevation myocardia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 5 days Whople procedure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence or). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Pancreatic Cancer Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed 1 ☐ Yes 2 🙀 No 2 🕽 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No မှ 1 Suppatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🔲 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) A44176435L100608 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S. Greene Spreet

Matthew Lewis

Balmoote, MP 2:20 Medical center 31. Date filed (Month, Day, Year) State NOV 2 3 2010 backs Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ $N_{\mbox{\scriptsize oV}}^{\mbox{\scriptsize Month}}$ 2010 Robert R. Holthaus, M.D. 21 5:05 Рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center Baltimore <u>Towson</u> 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year, 1 X M 2 □ F Days Hours Mary Land Months 217-38-0685 Director Usual Residence of Decedent show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a, State 10c. City, Town or Location 10d Inside City Limits with the Maryland Director 1 Yes 2XXNo Md.Baltimore Glen Arm 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 4109 Ravenhurst Circle 21057 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black White etc. þ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give Specify: 3 Widowed 4 Divorced Completed White and 2 should be filed within 72 hour Health and Mental Hygiene. Item 27 is marked other than "naturether traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Physician Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Holthaus Marv Niemever 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Holthaus/Wife 4109 Ravenhurst Circle Glen Arm, Maryland 21057 permit. Page 1 and 2 Der artment of Health Important: If item 2: any injury or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔲 Burial 2 🔀 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 11/23/10 Towson, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 Part 1. Enter the disease, or cour lications that caus. The death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Complications of metastatic line Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 ☐ Yes 2 ☐ No Yes within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No ၉ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 YOther (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00070635 11/22/10 30. Name and address of person of death (Item 23a) (Type, Print) N Charles St Ente 4105 Baltimore, 40 2120 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

NOV 23

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep		lental Hygie	ene
				rtificate of Death		No. U U 36/U9
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death
1 mining	Medic		Jeffrey John Healey 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	November	
لر	Examin	er	8139 Orchard Point Road	Pasadena		4c. County of Death Anne Arundel
77 ->	Funeral		5. Social Security Number 6. Sex 7, Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign
	Director		220-96-9572 1 ¹ X M 2 □ F 44 Yrs.	Months Days Hours Min.	Dec. 17,	1965 Country) MD
	d tow	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	postion		10d. Inside City Limits
	arylan a-f sh fied a	cto				1 ☐ Yes 2 🙀 No
	or 28; notii	Dire	MD Anne Arundel Pasa	10f. Zip Code	100	a. Citizen of What Country?
	with ti 23a d st be	eral	8139 Orchard Point Road	21122	109	USA
	tems tems	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,
36	", or i	þ	1 ☐ Never Married 2 ☒ Married Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give	1 ☐ Yes 2 ☒ No Specify:	nican, etc.)	Black, White, etc. Specify: 1.75 + 5
8	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed	3 U Wildowed 4 U Divorced Year or Dates.	dent's Usual Occupation		Wilte
15	an "na Media	ldm	(Specify only highest grade completed) (Give	kind of work done during most of worki O NOT use retired)	ing 16	b, Kind of Business Industry
212	within giene. ner thai t, the N		Elementary/Seconday (0-12) College (1-4 or 5+)	Sales		Building
pu	filed tal Hy d oth event	To Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Maid	den Surname)
Уlа	should be file and Mental is marked of raumatic eve		Thomas P. Healey, Sr.	Mary	Ann Leni	.ck
Mai	ge 1 and 2 should be filed within 72 hours after death with the Maryland tr of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at			ng Address (Street and Number or Rura		•
م	1 and 2 soft Health of Health of Health of them 27 other tra	13	Clare L. Healey Wife 813 20a. Method of Disposition 20b. Place of Disp	Orchard Point Ro		c. Location - City or Town, State
Baltimore, Maryland 21215-0036	Page 1 anent of land: If its		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, cre	matory or other place)	22/2010	•
altii	# P E E		Edite VIC	2. Name and Address of Facility		Sykesville, MD Reisterstown Road
m	permi Depar Impol any ir		Stephen M Jenkins	Eline Funeral Home		erstown, MD 21136
			Approximate Interval Between			
	Pnysician/	1	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	ome multi	forme	Onset and Death
-	Medical Examiner		resulting in death) de to (or as a consequence of):			
		er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
7	ted nsit	mim	Cause (Disease or iinjury			
μ	execu in and ial-tra	Ex	that initiated events resulting in death) Last C. Due to (or as a consequence of):	-		
09	ate be executed bhysician and the burial-transit	dical Examiner	d			
87	eath certifical attending ph	Me	IF FEMALE:			
Box 687	th cer ttend	ian/		Ectopic pregnancy		23d. Date of delivery Month Day Year
ğ	es that the dea signed by the a i be detached f	Completed by Physician/Me	1 Yes 2 No 9 Unknown Unknown 1 Yes 2 No 9 Unknown	Other (specify)		Wolfin Day Ioai
P.O.	hat the	y P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
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Ö	w require is been si 2 should	plet			24a. Was an	24b. Were autopsy findings available
Rec	s certificate has t	E O		_	autopsy performed 1 \(\sum \) Yes 2 \(\sum \)	
E	sian: ertifica ctor, p	Be	25. Was case referred to medical examiner?	26. Place of Death (Check		100 2210
Ž	Physic this coral dire	욘	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	,		e_6 Other (Specify)
0 0	ding F h. After funen	Certificate:	27. Manner of Death 1 Natural 5 ☐ Pending 28a. Date of injury (Month, Day, Year) 28b. Time of injury	f 28c. Injury at work? M 1 □ Yes 2 □ No	28d. Describe how in	njury occurred
sio	l or Attending after death. Director: After I in by the fune	rtifi	2		28f. Location (Street	t and Number or Rural Route Number,
Division of Vital Records,	al or safte		building, etc. (Specify)		City or Town, S	
_	Pospit t hour unera ed fille	Medical	29a. Certifier (Check (Check 2 Medical Examiner: On the basis of examination and/or invest	occured at the time, date and place, and	d due to the cause(s	s) and manner as stated.
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 144 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transic.	Me	only one) 3 Certifying Nurse Practioner: To the best of my knowledge,	death occurred at the time, date and place	e, and due to the cau	use(s) and manner as stated.
	5 V Vii		29b. Signature and the of certifier	29c. License number 41139	29d.	Date signed (Month, Day, Year) The Orlubely 18 2010
J			30. Name and address of person who completed cause of death (Item 23a) (Type,	<u> </u>		orluber 18 2010
	12			harter Drive, Colu	ımbia, MD	21044
	Stat	-	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
	Registra	ir	NOV 2 3 2010 Runs & Sales			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 240 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 15 2010 Year Theresa Anna Ingardia 9:20 A M 0 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2 Shady Grove Adventist Hospital Rockville Montgomery Social Security Number 3 **Funeral** 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛣 F Hours 123-14-9398 95 Jan. 5, 1915 New York **Director** BER Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director NOVEM 1 K Yes 2 No Maryland Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examiner must be Funeral 9701 Veirs Drive 20850 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 X Widowed 4 Divorced White Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) id Mental Hygiene, marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Seamstress Tailoring Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francesco Cappelli Arcangela Verrone off. Page 1 and 2 shours of Health and Mr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol DeClementi/Daughter 2200 Sherbrooke Way, Rockville, Maryland 20850 Department of Healt Important: If item 2 any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State November 2010 Montgomery Crematorium 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Robert A. Pumphrey Funeral Home, Rockville, Inc. 300 W. Montgomery Avenue, Rockville, Maryland 20850 willham M01173 hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications Approximate interval Between shock, or heart failure. List only one Immediate Cause (Final Onset and Death respirator Physician/ disease or condition resulting in death) minutes Medical Due to or as a consequence of): Examiner 1915 no 415 Sequentially list conditions, lary leading to immediate cause. Enter Underlying Cause (Disease or iinjury tract intection attending physician and for use as the burial-transi uninary that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Day 5 Other (specify) Month Year Pregnant at time of death 1 Yes 2 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾| 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) ျှ 1 ☐ Yes 2 🔀 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Npatient 2 ER/Outpatient 3 DOA within 24 hours after death. To the Funeral Director: After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) November 15, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) center Drive, Rockville, Mary land 20850 Wei Zhang, MD 9901 Medical 31. Date filed (Month, NOV 23 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Joseph Daniel Johns Physician/ 2010 5:30 MqNovember Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince George's County Hospital Prince George's Cheverly Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Funeral May 24, 1978 Days Hours 1 ₹ M 2 □ F 213-92-2346 $^{\prime\prime}$ Mb 32 **Director** Usual Residence of Deceden ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Anne Arundel Pasadena MD 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Vena Court 7721 21122 USA Funeral death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 2 1 Never Married 2 Married 21215-0036 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) within 72 (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Construction Worker Construction Be filed Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surna Marion Elizabeth and Mental F "Coffin Edward Johns Jr. Department of Health and Menta Important: If item 27 is marked any injury or other the Clarence pe 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7721 Vena Court, Pasadena, MD 21122 Marion E. Johns / Mother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 11/24/2010 Final Journey Crem. 4 Donation 5 Other (Specify) Woodbine, MD 22. Name and Address of Facility
Maryland Cremation Services
PO Box 141,3 Raltimore MD Funeral Service Licensee Dorota Marshal 21. Signatus 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as pardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or equend Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying physician and s the burial-transit Exam Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events bue to (or as a consequence resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? Month 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) Yes 2 No ed by the a detached f 9 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been signed to completed filled in by the funeral director, page 2 should be detected. Part II. Other significant onditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 500 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 10 2 🗌 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury//50 28c. Injury at 28d. Describe how injury occurred Fell 1 🔲 Natural 5 Pending roct November 3, 3010 1 Yes 2 □ No 2XAccident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Bural Route Number, City or Town, State) 9235 JANCY K determined buildes outside Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D28759 30. Name and address of person who completed cause of death (the BIJAN BAHMANYAR 3 23a) (Type, Print) Hospital Dr. Cheverly, M.D 3 001 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 23 2010 Registrar

10-00001	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legit	oie.
Leah Yasmine Jenkins	State of Maryland / Department of Health and Mental Hygiene	2

Lean Tasinine 5		otato of marylana, populario	te of Death		Z U I U g. No.	00112
Physicia Medical Exami	ın/	Decedent's Name (First, Middle,Last)	Jenkins	2. Date of Death Month November		3. Time of Death 2000 hrs
,		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Loc		4c. County of Death	
		1717 Green Meadow Court 5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Sevem	If Under 24Hrs. 8. Date of Birth	Anne Arundel	nolace (State or
Funeral Director		247-51-9648 1 M 2KF 29	Yrs. Months Days	Hours Min. Apr. 18		intryDC
aryland Ba-f show any	٦	Usual Residence of Decedent 10a. State	Location Seve	ern		10d. Inside City Limits 1 Yes 2 X No
17345 death with the Maryland or items 23a or 28a-f sho must be notifited at once.	Dire.	10e. Street and Number 1717 Green Meadow Court	10f. Zip Code 21144		g. Citizen of What Coun USA	try?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumaric event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 X Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year		nic Origin? (Specify Yes or No- exican, Puerto Rican, etc.)	14. Race - Americ White, etc. Specify: Black	
ours aff atural	ğ	15. Decedent's Education (Specify only highest grade completed) 16a. De	ecedent's Usual Occupation uring most of working life. DO	(Give kind of work done	16b. Kind of Business/li	
1036 vithin 72 h ene. er than "n Medical E	Completed	Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4	Logistics 1	l'echnician	Wholesale	
21215-0036 suld be filed within 7 Mental Hygiene. marked other than	B	17. Father's Name (First, Middle, Last) Amos Chuck Jenkins		Mother's Name (First, Middle, M Leah Ware		
MD 2. Id 2 should lith and M m 27 is m. aumatic e	۵			nd Number or Rural Route Num Circle, Severn		Zip Code)
Baltimore, I permit. Pages 1 and Department of Heal Important: If item injury or other tra		1 Burial 2 Scremation 3 Removal from State Final J	Disposition (Name of cemetry or other place) Ourney Crem.	11/24/2010		MD
Balti permit. Departi Import injury		21. Signature of Funeral Service Licensee Dorota Marshall Leuke L. Marshall	22. Name and Address of Maryland PO Box 1	Cremation S 413, Baltimo	Services ore, MD 21	203
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not failure. List only one cause on each line.	enter the mode of dying, suc	ch as cardiac or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Probable Cardiac Due to (or as a consequence of):	Arrnytimia			
È	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause				
uted Id ansit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.				
be exectician ar	Medical	▼ UNPENDED □ AMENDED 23a,27 per	me g912 2-11-	-11 vt		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunfal - transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Fetal death 3 1	Ectopic pregnancy	23d. Date of delivery Month D	ay Year
J. Bc t the dea		Part II. Other significant conditions contributing to death but not resulting i	n the underlying cause give	n in Part I. 23e. Did tob	pacco use contribute to t	he cause of death?
s, P.O. nires that th signed by d be detach	d by				2 No 3 Prob	· —
Division of Vital Records, its or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should the control of the funeral director.	Completed			24a. Was a autops perforr 1 ✓ Yes 2	y prior to coned? death?	opsy findings available ompletion of cause of
ital Reician: The scertificate	Be	25. Was case referred to medical examiner? Hospital: 1 Inspirate 2 FB/Out	- Ious	Death (Check only one)		
n of Vi ding Physi After this funeral dir	P.	1 ✓ Yes 2 No	patient 3 DOA DOA me of Injury a	Turbing Home of	Residence 6 Other:	Scene
ion (trendingleath.	ation	1 🖹 Natural 5 Pending 2 Accident Investigation (Month, Day,Year)	1 Yes	2 No		
Divisi pital or Att ours after de reral Direct filled in by	Certification:	3 Suicide 6 Could not be determined (Specify)	n, street, factory, office build	ling, etc. 28f. Location (S' or Town, St	treet and Number or Rui ate)	al Route Number, City
To the Hospita within 24 hours to the Funeral completely fille	Medical C	2ga. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or invand manner stated.				
	Ž	29b. Signature and title of certifier	29c. License nu O.C.M.E		29d. Date signed (Mon November 19, 20	
plean	+	30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner		Baltimore, MD 21201		
	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 2 3 2010 Access 6. Sacres				
Regist	Tell.	INUA NO EUTO KANANA SI. LAMBER				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Barbara Alvina Jones 20,2010 November 2:10 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Future Care Charles Village 5. Social Security Number 219-26-2160 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Months Days Hours Min (Month, Day, Year) Director 72 MD Usual Residence of Decedent shov 10a, State 10b. County within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 154 North Haven Street 21224 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 X Divorced Specify: Black Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Healthcare Microbiology Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked o မ Wiliams James Berthra pe Carey .. Page 1 and 2 should be treent of Health and Mer tant: If item 27 is marke jury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 154 North Haven Street, Baltimore, MD 21224 Lynn C. Harkless /Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial 2 🔀 Cremation 3 D Removal from State Department or Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crem. 11/25/2010 Woodbine, MD Signature of Funeral Service LicenseeDorota Marshall 22. Name and Address of Facility Maryland Cremation Services PO Box 1413, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cerebral Vascular Accident disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of): Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) ding physician Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No Day Year Month Pregnant at time of death g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records, Dementia 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2XXNo 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 2 🔀 No Other: 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4

✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) D 35102 November 22,2010

Registrar
DHMH 17 Rev 7/2009

State

5901 N. Charles Street, Baltimore, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Hilary Don, M.D.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Albert Johnson 6:05 Αм 2010 November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Stella Maris Hospice Center Towson 5. Social Security Numbe Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 XM 2 - F Months Davs Hours Month, Day, Year) September 27,1921 Country)
Maryland Director 220-09-2195 89 Usual Residence of Decedent 28a-f show 10b. County 10a, State 10c. City, Town or Location any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Tes 2 No Baltimore Dundalk Maryland 10e. Street and Number 10f. Zip Code ò 10g, Citizen of What Country? or items 23a Funeral 49 Broadship Road 21222 USA 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 XYes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 6:05 1 ☐ Yes 2 X No Specify: Specify: White marked other than "natural", Completed 3 XWidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. 2010 12 years Manager Grocery Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Lee Johnson Margaret Madaline Gabrial NOVEMBER 19, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S permit, Page 1 and 2 sh Department of Health ar Important: If item 27 is 1812 Leadburn Road, Towson, Maryland Mark Johnson son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State November 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Holly Hill Memorial Middle River, MD. 24, 2010 Signature of Fund ral Service Licensee 22. Name and Address of Facility
Connelly Funeral Home Of Dundalk, P.A.
7110 Sollers Point Road, Dundalk, MD. ntlow 21222 23a, Part 1. Enter the disease of complications that caused the death. on the enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ LUNG CANCER disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) bunial-transit law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Vital Records, P.O. Box 68760 phy: use as attending IF FEMALE; 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year Pregnant at time of death 5 Other (specify) Yes 9 Unknown been signed by the should be detached g Unknown ALBERT JOHNSON Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performed? Yes 2 X No Hospital or Attending Physician: The After this certificate 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 🗶 No funeral director, Be 26. Place of Death (Check only one) Hospital Other: မ 4 Nursing Home 5 Residence 6 N Other (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Division of 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate; injury work?
1 Yes 2 No Natural 5 Pending ithin 24 hours after death.

the Funeral Director: All ompleted filled in by the fu Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2
To the F only one 29b. Signature and title 29d. Date signed (Month, Day, Year) 30. Name and add ess of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year, State 32, Registrar's Signature

ORIGINAL

DHMH 17 Rev 7/2009

Registrar

Deneur S.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SR. 0:40 PM Nov Medical 4a. Facility Name (if not institution, give street and num 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A 8. Date of Birth Aug 31, 1920 If Under 9. Birthplace (State or Foreign Funeral Months 1 🛛 M 2 🗆 F Hours 90 Maryland 217-16-1052 Yrs Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director **Baltimore** Anne Arundel Maryland 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21225 Funeral 334 Holy Cross Road USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ş Maryland 21215-0036 1 Yes 2 X No Specify. If Yes Give White 3 Nidowed 4 Divorced Completed WW 2 Year or Dates. the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) Bethlehem Steel Corp. College (1-4 or 5+) Shipbuilder 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Floyd Howard Jacobs Dorothy Wayson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 131 Coralwood Road, Pasadena, Maryland 21122 Floyd William Jacobs, Jr. (Son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 11/19/2010 Glen Haven Mem. Pk. Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 21. Signature of Fundral Serv Licensee Kevin E Ecker 237 E. Patapsco Avenue, Baltimore, Maryland 21225-1856 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) 2 weeks Examiner Sequentially list conditions it any leading to immedicause. Enter Underlying Cause (Disease or iinjury that initiated events sician and burial-transit Exami requires that the death certificate be executed resulting in death) Last attending physician for use as the burial Physician/Medical Dementla Box 68760 IF FEMALE: 23d Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Pregnant at time of death 3 T Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Yes 2 No 9 Unknown Division of Vital Records, P.O. q Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed the should be detailed ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed page 2 should Sacral decubitus ulcer 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 certificate 1 Yes 2 No To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director, After this certifics completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death 28d. Describe how injury occurred Certificate: Natural injury work?
1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 6418 Centennial circle 6/en burne 20061 npleted cause of death (Item 23a) (Type, Print) MD 32. Registrar's Signature State

ADHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	Cei	tificate of D			eg. No.	2021
	Physicia	-/	1. Decedent's Name (First, Middle, Last)				2. Date of Deat	- Ima W 1 W	3) Time of Death O
-	Medic		Louise Hazlehurst Knust				Novembe:	r 19, 2010	8:20 PM
	Examin	er	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or		1	4c. County of Dea	
and the	Funeral		Gilchrist Center 5. Social Security Number 6. Sex 7. Age (In yrs. la	ast birthday)	Towson If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	I g. B	rthplace (State or Foreign
	Director		217-26-0083 1 M 2XD F 83		Months Days	Hours Min.	(Month, Day, Aug 6,	1927 Ma	ryland
	d ow	_	Usual Residence of Decedent 10a. State 10b. County 10c. City	, Town or Lo	oction				10d. Inside City Limits
	arylan a-f sh fied a	Director	, , , , , , , , , , , , , , , , , , , ,						1 Yes 2X No
	or 284		Maryland Baltimore 10e. Street and Number	Tows	10f. Zip Code		- 1	0g. Citizen of What C	
	with t	Funeral	615 Chestnut Avenue		21	204		USA	
	items items		11. Marital Status 12. Was Decedent Ever in U.S	13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi	
36	after	d by	1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	1	1 ☐ Yes 2 🏹 No		, ,	Specify: Wt	
8	filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho yevent, the Medical Examiner must be notified at	Completed	15. Decedent's Education	16a. Decer	dent's Usual Occupa	ation		16b. Kind of Busines	s Industry
215	(Give kind of work done during most of work to be seen that the control of the co						rking		,
7	ygien ygien her th	Be Co	4	Home	emaker			Own Home	9
and	ntal H red ot ed ot	To B	17. Father's Name (First, Middle, Last)				ne (First, Middle, N	laiden Surname)	
Ĕ	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "any injury or other traumatic event, the Medical Examiner must be notified at once.	ľ	Hugh J. Hazlehurst 19a. Informant's Name/Relationship (Type, Print)	10h Mailin	a Addross (Street a		Baugher	City or Town, State, Z	in Code)
Š		١.	Kathleen Knust, Daughter		,			, Maryland	
e,	of Health of Health fitem 27 r other tra	М	20a. Method of Disposition 20b. P	lace of Dispo	sition (Name of matory or other place			20c. Location - City o	
Ē	Page 1 ment of ant: If it ury or o				ematory I		/22/10	Baltimore,	Maryland
Baltimore, Maryland 21215-0036	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Licensee Thomas Gregor	Š	Name and Addres remation 99 Freder	Society ick Road	Of Maryl Baltim	and, Inc. ore, Maryl	and 21228
			23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.						Approximate Interval Between
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	/ Medical Examiner		disease or condition resulting in death) a. Due to (or as a consequ	ence of):				24	
		er	Sequentially list conditions, if any, leading to immediate	and a title			0	Pon 1	inelles
	ted Insit	Examiner	cause. Enter Underlying Cause (Disease or iinjury		7/20				
	execu an and rial-tra		that initiated events resulting in death) Last C. Due to (or as a consequence of the c	ence of):			J'Ily	101	
8760	ificate be executed g physician and as the burial-transit	Medical	d				13/1/1/3/	2	
	# 50 E		IF FEMALE: 23c. If yes, outcome of pregnar	ncv		17	13	T	
Box	requires that the death cert teen signed by the attendir should be detached for use	Completed by Physician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 4 Pregnant at time of d	death 3	Ectopic pregnancy Other (specify)	y // <	Swill	23d. Date of do Month	Day Year
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P.0.	requires that the t een signed by the should be detach	by F	Part II. Other significant conditions contributing to death but not resu	,	, ,				o the cause of death?
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000	law has e 2	mpl					24a. Was ar autops	y prior to	utopsy findings available completion of cause of
ř	ician: The certificat P ector, page		25. Was case referred to medical		26 Dia	ace of Death (Che			es 2 🗆 No
Vita	ysicia s certi directe	To Be	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2	ER/Outpatier	Othe	P1		nce 6 N Other (Spe	city) tespice
0	ng Ph ter thi			28b. Time of injury		at	28d. Describe ho		3177
<u>o</u>	tendii leath. tor: Ai the fu	Certificate:	2 W Accident Investigation 10176/10	unthor	vh ^M 1 .	Yes 2 🔀 No	Fall		
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Cert	4 ☐ Homicide determined 28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (Str City or Town, Pic (cerson)	eet and Number or Ri State)	s chestnut the
	spital hours neral d filled	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowle	edge, death	occured at the time,	date and place, a	and due to the caus	e(s) and manner as s	ated.
	he Ho lin 24 he Fu hpleted	Med	(Check 2 ☐ Medical Examiner: On the basis of examination only one) 3 ☐ Certifying Nurse Practioner: To the best of my						
	To I		29b. Signature and title of certifier		29c. License		47	9d. Date signed (Mon	
	₽.		- Miland	00 a) T		07063	ウ	11/2011	U
)			30. Name and address of person who completed cause of death (Item	Langly (Iype, F	es St Sn	nte 41	us Ball	Ltimure M	D 21704
	Stat		31. Date filed (Month, Day, Year) 32. Registrar's Signati						,
	Registra	ir	0 0 2010 6 1						

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TITEM#8perFH, G910, 12729 F20116, WS.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Elaine C. Karpenko :51p^M 201 Medical ovembe 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Greater Baltimore Medical Center . Social Security Number Od Month, Day Year 1931 . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Country) MD 1 🗆 M 2 🗓 F Months Davs Hours Min. 214-30-6825 79 Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Baltimore Cockeysville 1 Yes 2X No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10512 Abbey Rd 21030 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ☐ Yes 2 No Specify: If Ves Give 3 X Widowed 4 Divorced Specify: Completed White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) e 1 and 2 should be filed of Health and Mental H If item 27 is marked ot or other traumatic ever 2 C. Wilson Hooper Theresa C. Ahlors 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrick D. Hanley (Attorney) 117 Lakefront Dr Hunt Valley, MD 21030 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 1
Burial 2
Cremation 3
Removal from State 4 Donation 5 Other (Specify) Bayview Crematory 11-22-2010 Baltimore, MD permit. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home of BelAir Inc 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final OBSTRUCTIVE PULMONAR CHRONIC Physician/ OPD disease or condition resulting in death) Medical Due to (or as a consequence of) 10YRS Examiner Sequentiary flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) signed by the attending physician and be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Year Pregnant at time of death Month Day 4 ☐ Pregnant : 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No After this certificate 2 No 1 Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No 1 Yes Other: ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Acciden (Month, Day, Year) 5 Pending within 24 hours after death.

To the Funeral Director: Al
completed filled in by the fu 1 Yes 2 No Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one Comflying Nurse Practioner: To the best of my knowledge: death of at the time, date and plane, and due to 29b. Signature and title of certifier ealthah Min 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EUGENE A OBAH, MD MD 21204

Registra DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

NOV

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 245PM November 22 2010 Marjorie R. Keys /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N/A thospita Sydmitle Agnes Date of Birth Birthplace (State or Foreign Country) ____ Age (In yrs. last birthday) **Funeral** 10/17/1924 Hours Months Davs 1 □ M 2 □MF 86 Illinois Director 347-14-5265 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show event, the Modical Examiner must be notified at Director Catonsville 1 ☐ Yes 2 No Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or United States 715 Maiden Choice Lane HR429 21228 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 | Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 No Specify: þ Specify: White 3 □ Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens Important: If item 27 is marked other the any injury or other traumatic event, the 1 once. Medical Registered Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marie McLaughlin John Lee Reilly ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3943 Bayside Drive, Edgewater, Maryland 21037 Daniel T. Keys (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/23/2010 MD Vets-Crownsville Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Hupotension Due trans as a consequence of r /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-trar Due to (or as a consequence of): Kays / Marjoria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Ye ar 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown ranal certificate has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy death? 1 ☐ Yes 2/1No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: , d in by the f 6 Could not be determined 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours after To the Funeral Directory Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

0

Baltimore, Maryland 21215-0036

State Registrar

29b. Signature and title of certifier

MD 32. Registrar's Signature (Month, Day, back

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D30989

Maiden Choice Ln Cotonsville MD

NOVamber 22 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydienes

	•	For State Registrar	State of M	aryland /	-	riment of H			Reg. No.	010	36719
Physicia Medic		1. Decedent's Name (First, Midd Far1 Kenne						2. Date of De Month NOVEME		Year 2010	3. Time of Death 03:45A M
Examin		4a. Facility Name (if not institution		CENTE	4b. City, Town, or Location of Death					ounty of Death	IMORE
Funeral Director		5. Social Security Number 217–50–3969	6. Sex 7. Ag	ge (In yrs. last birthday) If Under 1 Year If Under 24 Hr. Months Days Hours Min				8. Date of Bir (Month, Da Dec. 17	y, Year)	Cour	place (State or Foreign try) inia
Maryland Ba-f show tified at	Director	Usual Residence of Decedent 10a. State 10b. Count Maryland N/A	у	10c. City, To	wn or Loc					10d. Inside City Limits	
with the I 23a or 2 ust be no	Funeral Di	10e. Street and Number 4323 Newport Aven	ue	•		10f. Zip Code	21211		10g. Citizer	n of What Cou	ntry?
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item Z7 is marked other than "natural", or items Z3a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 😾 Divorce	If Von Cive			/as Decedent of His Yes, specify Cubar ☐ Yes 2★★No		ecify Yes or No- Rican, etc.)		Race - Americ Black, White, ecify: Wh	
vithin 72 houl jiene. er than "natu the Medical	Completed		ent's Education nest grade completed) College (1-4 or		(Give ki life. DC	ent's Usual Occupa ind of work done do NOT use retired) Oprietor		ing	16b. Kind of Business Industry Hardware, Store		
l be filed v fental Hyg rked othe tic event,	To Be	17. Father's Name (First, Middle, Farl Klock	Last)	'			18. Mother's Nam Janet	ne (First, Middle, Poff			-
d 2 should alth and N 27 is ma er trauma		19a. Informant's Name/Relation Rachael Klock	ship <i>(Type, Print)</i> Daughter	1!		Address (Street a. 12 Lochlea					Code)
Page 1 an nent of He ant: If iten ıry or oth	econs.	20a. Method of Disposition 1 ☎ Burial 2 ☐ Cremation 4 ☐ Donayon 5 ☐ Other		ceme	tery, crem	ition (Name of atory or other place 11ey Memori)	Date 2/2010		tion - City or To um, Mary	
permit. Departr Importa any injt		21. Signature of Funeral Service	B. Hens	S	180 36	Name and Address rgee Henss 31 Falls Ro	Seitz Fune ad, Baltin	ral Home, ore, Mary	Inc. land	21211	
Physician/		23a. Part 1. Ever the disease, on shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on each lin	e.	o not enter	the mode of dying	, such as cardiac	or respiratory ar			Approximate Interval Between Onset and Death
Medical Examiner		resulting in death)	Due to (or as	a consequence	e of):	RDIOM	YOPAT	HY			
and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	a. TSCH Due to (or as b. TSCH Due to (or as	STAGE a consequence	e vi).	ENAL	DISEA	SE			
icate be executed I physician and s the burial-transit	ledical E	resulting in death) Last	d	a consequence							
ath certific attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1									ery Day Year
i aw requires that the de has been signed by the le 2 should be detached		Part II. Other significant condit	ions contributing to death t	out not resulting	g in the un	derlying cause give	en in Part I.		obacco use Yes 2		he cause of death?
The law requate the contract of the law beer page 2 shou	Completed by							24a. Was autoj perfo		24b. Were auto prior to co death? 1 Yes	psy findings available impletion of cause of
/sician: 7 s certifica director, p	To Be C	25. Was case referred to medica examiner? 1 Yes 2 No	Hospital: \	ient 2 🗆 ER/0	Outnatient	Othe	ce of Death (Chec	k only one)			
nding Phy uth. : After this e funeral c		27. Manner of Death 1 Natural 5 ☐ Pend	28a. Date of inju	ıry 28b	o. Time of injury	28c. Injury work?	at	28d. Describe			
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director. After this certificate completed filled in by the funeral director, pag	Certificate:	3 Suicide 6 Coule	I not be		farm, stre	et, factory, office		28f. Location (\$ City or Tox		umber or Rura	l Route Number,
ne Hospi i n 24 hour ne Funer pleted fill	Medical	(Check 2 Medical	g Physician: To the best of Examiner: On the basis of e g Nurse Practioner: To the	examination and	d/or investi	gation, in my opinior	n, death occurred a	t the time, date a	and place, an	id due to the ca	use(s) and manner stated.
Vithi Construction		29b. Signature and title of certific		p 00		29c, License	number 5206 5	5	29d. Date s	igned (Month,	Day, Year)
10		30. Name and address of person RONALD D.			a) (Type, Pr	int) 601 051	ER DRI	VE TO	w so	NMA	2010 21204 PRYLAND
Stat Registra		31. Date filed (Month, Day, Year)		ar's Signature				- 		7	1-

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760 系

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 November 12:10PM Andre Kemmer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calloway St. Mary's Hospice of St. Mary's 9. Birthplace (State or Foreign Country) Maine 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Hours 1 🕱 M 2 🗆 F (Month, Day, Year) 02/09/1943 Director 227-58-8385 67 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at Director 1 X Yes 2 No St. Mary's Lexington Park 10e. Street and Number 10g, Citizen of What Country? Funeral with 21895 Pegg Rd. #219 20653 U.S.A items within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ō þ 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3 X Widowed 4 Divorced Specify: White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Hair Dresser Cosmetology Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important; If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kemmer Grace Marion 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Dean / Sister 24625 Hollywood Rd., Hollywood, MD 20636 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State Anatomy Gifts Registry 11/23/2010 | Hanover, Maryland 4 X Donation 5 ☐ Other (Specify) Signature of Funeral Sen 22. Name and Address of Facility Anatomy Gifts Registry nsee 7522 Connelley Dr., Ste. P, Hanover, MD 21076 or-complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Approximate Interval Between and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury attending physician and for use as the burial-transif that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 No detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cances page 2 should be Records, The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 MO2 certificate 1 Yes 2 🗌 No Division of Vital or Attending Physician: . Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 No HUSBICE မ 1 Inpatient 2 ER/Outpatient 3 I DOA 6 Y Other (Specify) Home 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending 1 🗆 Yes 2 🗆 No Investigation 6 Could not be 24 hours after death Funeral Director: / 2 Accident the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar

22650 Cevar 14ne c7

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

uresh

31. Date filed (Month, Day, Year)

MOUG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 David Kashansky <u>November</u> Medical 9:40AM 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death and Rehab Rockville Montgomery Shady Grove Nursing Home 8. Date of Birth (Month, Day, Year) October 26,1940 7. Age (In yrs. last birthday) If Under 1 Year | if Under 24 Hrs. **Funeral** ecurity Number 9. Birthplace (State or Foreign Days 1 X M 2 □ F Months Hours Min Yrs New York Director 70 091-32-1434 Usual Residence of Decedent *show or 28a-f shov e notified at 10a. State 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral with 9701 Medical Center Drive 20850 United States filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ⚠ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married ≥ Baltimore, Maryland 21215-0036 it. Page 1 and 2 should be filed within 72 hours an artment of Health and Mental Hygiene.

ortant: If item 27 is marked other than "natural" ortant: If item 27 is marked other than "natural". If Yes, Give 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 Divorced unk Specify Completed Year or Dates White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 General Manager <u>Automotive</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Paul Kashansky Vera Gershansky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7966 Parkland Place, Frederick, Maryland 21701 <u>Rhonda Roberts/ Daught</u>er 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important; If any injury or November 4 Donation 5 Other (Specify) Parklawn Memorial Park 2010 Rockville, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signature of Funeral service Licensee M00335 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician/ Aspiration Pneumonia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Dysphagia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and bunial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be Box 68760 the SS IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months?

1 Yes 2 No Month Day Year the 9 Unknown 9 Unknown of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 ☐ Yes 2 🔀 No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 K Nursing Home 5 Residence 6 Other (Specify) 1 \(\text{Yes} 2 🗶 No ည 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury 28b. Time of within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending Division 1 🗌 Yes 2 🗌 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Certifying Nurse Bractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified 29c, License number 29d. Date signed (Month, Day, Year) D0062435 November 22, 2010

Registrar
DHMH 17 Rev 7/2009

State

10110 Molecular Drive, #206 Rockville, Maryland 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Sayed Elsayyad, 31. Date filed (Month, Day, Year) NOV 23 2010 Legible. 3. Time of Death 20°1'0 1:40 A M ounty of Death

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			for State Registrar	State	Of Ivial yie			tificate of i			ientai riy	Reg. I	20	10	36	72
			1. Decedent's Name (First, M.	iddle, Last)							2. Date of De	eath			3. Time	of Death
	Physici Medi		Mary	Burns	Knies						Novemb	er '	Î6,	20°1′0	1:4	0 A
l.m.	Exami		4a. Facility Name (if not institu	ition, give street and n	umber)			4b. City, Town, c	or Locatio	n of Death		4	c. County	of Death		
~			Ingleside a	t King Far	m		- 1	Rockvi	11e				Mont	gomei	У	
	Funeral		5. Social Security Number	6. Sex 1 □ M 2 🗓 F	7. Age (In yrs	. last birth		If Under 1 Year Months Days	If Und	er 24 Hrs. Min.	8. Date of Bi	rth	-)	g. Birth	place (State	or Forei
	Director		263-40-7839		82	Y	rs.	months Baye			(Month, Da August	29,	1928	Geo	orgia	
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	e Ma r 28g notif	Dire	10e. Street and Number			KOCKV	, 111	10f. Zip Code				40	0141	100		
	ith th	ral	701 King Far	m R137d #	625			20850				_	Citizen of ' I nite			
	ms 2 mus	nue	11. Marital Status		ecedent Ever in (10	12 \	as Decedent of F		Origin? (Spo	oify Voc or No					
40	r dea or ite		1 Never Married 2	Armed	Forces?	J.G.	lf. If	Yes, specify Cub	an, Mexic	an, Puerto l	Rican, etc.)			e - Ameri ck, White,	can Indian, etc.	
38	all", c	q p	3 Widowed 4 Divo	rced If Yes, O	s 2 X No Give		1	☐ Yes 2 🕅 No	Speci	fy:			Specify	Whi	te	
ŏ	hours hatur ical I	Completed by		edent's Education		16a. I	Decede	ent's Usual Occup	oation			16b.	Kind of B	usiness Ir	dustry	
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р	filed al Hy t oth vent	Be	17. Father's Name (First, Midd						18. Mo	ther's Name	(First, Middle	, Maide	n Surnam	e)		_
<u>la</u>	d be Menta	잍	Gordon Neum	nan Burns					Hi1	da Sm	ith					
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relati	ionship (Type, Print)		19b.	Mailing	g Address (Street	and Num	ber or Rura	Route Numbe	er, City	or Town, S	State, Zip	Code)	
	nd 2 saith n 27 er tr		John B. Knies	s / Son		39	21	Poole Ro	ad F	<u>'inksb</u>	urg, Ma	ary:	land	2104	8	
Baltimore,	of He roth		20a. Method of Disposition 1 Burial 2 X Crema:	tion 2 Demoval for	01.44	cemeters	v crem	ition (Name of atory or other pla	ce)	Morromb	er 19,	20c.	Location	- City or T	own, State	
<u>Ĕ</u>	Page nent o		4 Donation 5 Oth		Mo Cr	ntgoi	meri	im. Inc.	/	201	0	Be	thes	da. N	laryla	nd
alt	permit. Page 1 a Department of H Important: If ite any injury or ot		21. Signature ungral Serv	ice License /			22.	Name and Addre	ess of Fac	ility	1 77				-	
<u> </u>	9 9 E 18 18		Fill L	filed	M01607		1300	pert A.) W. Mon	rump	nrey E erv A	uneral H Zenue F	ome Rock	Rock vill	ville e Mar	vland 2	0850
			23a. Part 1. Enter the disease shock, or heart failure. L	e, or complications that ist only one cause on	at caused the de	ath. Do no	ot enter	the mode of dyir	ng, such a	as cardiac o	respiratory a	rrest,			Approxima Interval Be	ate
	Physician/	8 9	Immediate Cause (Final disease or condition		roke										2 day	Death S
€	Medical		resulting in death)	Due f	to (or as a conse									_		
	Examiner	L	Sequentially list conditions,	At	rial Fi	brill	lati	Lon							Years	
		Examiner	dany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due 1	tu (ur as a curise	quence of	f):							79		
	executed an and ial-transi	(am	that initiated events	U	pertens										Years	
	exec ian al irial-t	1- 1	resulting in death) Last	Due t	o (or as a conse	equence of	f):									
00	certificate be nding physici use as the bu	dic		d												
87	tifica ing p	ğ.	IF FEMALE:													
Box 68760	ath certificate be executed attending physician and for use as the burial-transit	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, o	outcome of preg ve Birth 2 Fe	nancy etal death		Ectopic pregnan	су					te of deliventh	ery Dav	Year
Bo	death of the atternated for u	Physician/Medica	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4 ⊔ Pr 9 □ Ur	egnant at time c nknown	of death	5 🗀	Other (specify) _					IVIC	лип	Day	Teal
P.O.	at the d by etacl	Ph	Part II. Other significant con	ditions contributing to	death but not r	esultina in	the un	derivina cause ai	iven in Pa	rt I.	23e Did i	hobacco	use cont	ribute to t	he cause of	death?
	requires that the de been signed by the should be detached	Completed by	adult failur	e to thriv	е			,g g							bably 4	
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Records,	≥ 0 0 l	ldu	dementia								24a. Was			Were auto prior to co death?	psy findings impletion of	cause of
Be	an: The la tificate ha tor, page?										1 🗆 Yes		No	1 Yes	2 🗌 No	
-	i ii ii	ψ.	25. Was case referred to med	ical				26. P	lace of D	eath (Check	only one)					

d. Date of delivery Month Day Year contribute to the cause of death? No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 4 K Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

11-16-2010

Bethesda, Maryland 20814

9. Birthplace (State or Foreign Georgia

10d. Inside City Limits 1 X Yes 2 □ No

Division of Vita To the Hospital or Attending Physiciar within 24 hours after death.

To the Funeral Director: After this certif completed filled in by the funeral directo

examiner?

은

Certificate:

Medical

1 🗌 Yes

27. Manner of Death

1 🛛 Natural

29a. Certifier

(Check only one) 29b. Signature and title of certifie

Accident

Suicide

☐ Homicide

2 🔀 No

Roy Fried, M.D.

31. Date filed (Month, Day, Year)

NOV 2 3 2010

5 Pending

Investigation 6 Could not be

determined

Hospital:

Name and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of injury (Month, Day, Year)

32. Registra 's Signa

State Registrar 7758 Wisconsin Avenue Suite 211

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

injury

28c. Injury at work?
1 Yes 2 No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D34590

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For
State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 17 2010 Year nMann -10 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Manor Care Bethesda Bethesda 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Hours Min New York 098-24-6760 78 Yrs Director Sept. Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland 10a. State Director Maryland Montgomery Silver Spring 1 ☐ Yes 2 X No 10g. Citizen of What Country? ŏ 10e. Street and Number 10f. Zip Code must be 23a Funeral 20910 United States 1613 Highland Drive Hygiene. other than "natural", or items Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: Completed 3 Wildowed 4 Divorced Year or Dates 1 and 2 should be filed within 72 hours of Health and Mental Hygiene.
item 27 is marked other than "natur other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life, DO NOT use retired) during most of working College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Director of Education Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Helen Weinstein Max Kleinmann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Maury Kleinmann/Wife 20910 1613 Highland Drive, Silver Spring, MD or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of I-Important: If ite any injury or ot 20, 1 Burial 2 X Cremation 3 Removal from State November Montgomery Crematorium 4 ☐ Donation 5 ☐ Other (Specify) 2010 Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Fun-7557 Wisconsin Avenue, 21. Signature of Funeral Service Licer Funeral Home, nue, Bethesda Bethesda-Chevy Chase, Inc. Maryland 20814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Myocardial Infarction Medical resulting in death) Due to (or as a consequence of) Examiner Years Atherosclerotic Heart Disease Sequentially list conditions, it any, leading to incredible cause. Enter Underlying Due to (or as a consequence of, Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last as the burial attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Yes 2 No the detached g 🗌 Unknown ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? ☐ Yes 2 **X** No certificate 1 🗌 Yes completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 **X**No ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 24 hours after death. Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D19609

DHMH 17 Rev 7/2009

State Registrar

Division of Vital Records, P.O. Box 68760

32. Registrar's Signature

10810 Darnestown Road #202, Gaithersburg, Maryland

20878

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Raman R. Tuli, M.D.

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2 0 | 0

,			e of Death	Reg.	. No.					
Physicia	an/	Decedent's Name (First, Middle,Last)		. Date of Death		3. Time of Death				
edical Exami	ner	racy Josephine Larkin		Month E November 1		0921 hrs				
		Facility Name (if not institution, give street and number) A316 Hampton Hall Court	4b. City, Town, or Location of Death Belcamp		4c. County of Death Harford					
E a small		Social Security Number 6. Sex 7. Age (In yrs. last birthda		8 Date of Birth	(MM/DD/YYYY) 9. Birth	nolace (State or Foreign				
Funeral Director			Months Days Hours Min.		Cou	ntry) nsylvania				
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he Maryland or 28a-f show fied at once,	양	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Coun	try?				
he Mz	Director	4316 Hampton Hall Court	21017	11	Inited Stat	es				
34 with th			3. Was Decedent of Hispanic Origin? (Spec		14. Race - Americ					
leath r item	Funeral	1 Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican, Puerto Ri	can, etc.)	White, etc.					
after o	by F		1 Yes 2 No specify:		Specify: Whi	te				
ours natur		duri	edent's Usual Occupation (Give kind of working most of working life, DO NOT use retired		6b. Kind of Business/In	idustry				
5-0036 ted within 72 hou Hygiene. other than "na	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		,	Haalah Ca	** 0				
5-003 led within tygiene. other th	Ę	17. Father's Name (First, Middle, Last)	Nurse 18.Mother's Name (F	Test Middle Mo	Health Ca	re				
filed filed ed otl			To.Mottlet's Name (F	iist, Middle, Ma		NT				
D 2121 should be fil and Mental F 7 is marked natic event, in	o Be	Henry T. Larkin 19a. Informant's Name/Relationship (Type, Print) 19b. N	lailing Address (Street and Number or Ru	ral Route Numbe	UNKNOW er, City or Town, State,					
AD 2 shot and 27 is martic			Dukes St., PO BOX 282							
Paltimore, MD 21215-0036 7346 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-7 she injury or other traumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition 20b. Place of D			20c. Location - City or 1					
nor of he of he		Burial 2 Xicremation 3 Removal from State		2/2010	Baltimore,	Maryland				
altir nit. I sartme porta			22. Name and Address of Facility Crem							
E F P E			299 Frederick Rd., E							
Physician		23a. Part I. Chter the disease, or comprications that caused the death. Do not enfailure. List only one cause on each line.	nter the mode of dying, such as cardiac or re	espiratory arrest	t, shock, or heart	Approximate Interval Between Onset and				
Examiner	1	Immediate Cause (Final disease a. Subarachnoid Ho	emorrhage			Death				
		or condition resulting in death) Due to (or as a consequence of):								
	<u>ا</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):								
**	틭	cause. Enter Underlying Cause		321 -2						
ed nsit	Examine	events resulting in death) Last Due to (or as a consequence of):								
Sox 68760, death certificate be executed te attending physician and for use as the burial - transit		x UNPENDED AMENDED 23a,27 per	me g910 12-27-10 vt	-		·				
60, ate be o	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery					
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Box 687 he death certific y the attending p	Si	4 Pregnant at time of death 5	Other (Specify)							
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ires that the signed by the detache	ē	THE COURT OF THE C	and directlying dadge given in Fair i.		2 No 3 Proba					
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tal Records cian: The law requi certificate has been	ខ្ញ		26.Place of Death (Check onl	1 ✓ Yes 2	No 1 ✓ Yes	2 No				
Division of Vital Records, tal or Attending Physician: The law requires after death. 1a Director: After this certificate has been sited in by the funeral director, page 2 should the	å	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpa	Other		esidence 6 Other:	Scene				
n of Vita	£	Tes 2 No			w injury occurred					
arth.	흷	Natural 5 Pending	1 Yes 2 No							
ivision l or Attencather death Director:	fica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm,	street, factory, office building, etc. 28		eet and Number or Rur	al Route Number, City				
Divisior pital or Attend ours after death peral Director: filled in by the	Certification:	4 Homicide determined (Specify)		or Town, Stat	(e)					
Di To the Hospital within 24 hours a To the Funeral I completely filled		29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death								
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or inve								
	Σ	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mon					
		Hamit Hulhall M)	O.C.M.E.		November 20, 20	10				
1 x s		30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner	111 Penn Street, Baltimore, MD	21201						
of pero	ate		Chil Ottock, Dalumore, Wic							
Regist		110 y 2 2010 1 8 1 4								
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Josephine M. Leedy November 2010 3:45 Р Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Pickersgill, Inc. Towson Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Birtrip Country) PA **Funeral** 1 □ M 2 ⋤ F Jan. 25, 1914 Months Days Hours Min. 96 Director 211-03-2137 Usual Residence of Decedent 28a-f shov 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 X No MD Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 615 Chestnut Avenue 21204 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ş 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Nursing Assistant and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Heath and Menta Important if item 27 is marked any injury or other traumatic conce. ၉ Glenn Ford Verna M. Knight 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Geist-Brother-in-Law 20 Clifton Terrace; Carlisle, PA 17013 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Meadowridge Mem. Park 11/29/2010 Elkridge, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 Signature of Funeral Service Littinge Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Stranc Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown cate has been signed by the page 2 should be detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown To the Hospital or Attending Physician: The law requin within 24 hours after death.

To the Funeral Director: After this certificate has been completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No ္ဝ 1 Inpatient 2 ER/Outpatient 3 DOA 4. Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending work? 1 Yes 2 No M Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29c. License number

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

SAE 4105

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician/ Parvis Lish 5:00A M Georgia November Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Northwest Hospital/Seasons Hospice Randallstown 9. Birthplace (State or Foreign Country) 1917 Maryland 8. Date of Birth (Month, Day, Y March 21 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕱 F Months Days Hours Min. Director 169-32-8480 93 March Usual Residence of Decedent 3a or 28a-f show t be notified at 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State Director 1 🗌 Yes 2 🔀 No MD Baltimore Catonsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Funeral th and Mental Hygiene. It is marked other than "natural", or items 23a traumatic event, the <u>Medical Examiner must b</u> USA 8 Overbrook Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give þ 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 ☑ No Specify: Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home <u>Homemaker</u> Be filed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be fi of Health and Mental item 27 is marked 2 Julian P. Robinson Georgia W. Wamsley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 45 Willis Drive; Shephardstown, West VA Julian Lesh Son Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition (of h 1 Burial 2 X Cremation 3 Removal from State ò permit. Page Department o Important: If any injury or 11/19/2010 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory Glen Burnie, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. Signature of Funeral Service Licensee MO1050 630 Edmondson Avenue: Catonsville MD 23a. Part 1. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atheroscie Rotic Cardiovascular Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, riary, reading to infractiate cause. Enter Underlying Cause (Disease or iinjury Due to (or es e consequence of): Examine burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last physician Completed by Physician/Medical that the death certificate be Box 68760 the attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year signed by the aid be detached for g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 🗋 No 3 🗎 Probably 4 🗹 Unknown Division of Vital Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? ils certificate has director, page 2 s autopsy performed Yes 2 No 2 No 1 🗌 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be 4 Nursing Home 5 Residence 6 Other (Specify) examiner? Hospital: Other: Certificate: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at work? After 1 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No o 24 hours after death e Funeral Director: A lleted filled in by the fi Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Pertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2

To the comple 29d. Date signed (Month, Day, Year) MS Rujapahrem. D 11/17/10

State Registrar 31. Date filed (Month, Day, Year) 32. Rigistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AV- 5- 203, Balhmore, MD, 21209.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ David Lee Lanier November 19, 2010 Year 8:00 PM M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/A 3801 Roland Avenue Baltimore 3 8 1 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** July 12, 1950 1 **X** M 2 □ F Months Hours Min Director 219-52-3851 Maryland 60 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Maryland N/A Baltimore 1 X Yes 2 □ No ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 3801 Roland Avenue 21211 USA death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian. Black, White, etc. "natural", or Completed by 1 Never Married 2 Married 1 X Yes If Yes, Give 2 No Saltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2XX No Specify: Specify: White Viet Nam 3 ☐ Widowed 4xxDivorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work dane during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Community College of Baltimore County Dundalk nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Teacher 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o John Franklin Lanier Clara Amelia Waddev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kira Lanier Daughter 517 Tolna Street, Baltimore, Maryland 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Olivet Cemetery 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 11/24/2010 Baltimore, Maryland 4 Donation 5 Other (Specify) Signature of Functal Service Name and Address of Facility Burgee Henss-Seitz Funeral Home, Inc 3631 Falls Road, Baltimore, Maryland Lice Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, Medical resulting in death) Due to or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events as a consequence of The law requires that the death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 as the IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Pregnant at time of death 5 Other (specify) the 9 Unknown detached g 🗌 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ page 2 should be Division of Vital Records, 3 Probably 4 Unknown Completed 1 Tyes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one examiner? ၀ 1 Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the only one) re and title of certifie 29b. Signat 29c. License number signed (Manth, Day, Year,

Registrar

30. Name and address of person who completed cause

Falls Road

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Irene Ledlow November 2010 4:45 \mathbf{P}^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4322 E. Eager Street Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 🔀 F December 6, 1933 Maryland 214-30-7173 Director 76 Usual Residence of Decedent or 28a-f show notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director N/A Maryland 1 X Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò or than "natural", or items 23a or the Medical Examiner must be Funeral 4322 E. Eager Street 21205 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married þ Yes 2 XNo Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes Give White 3 ₩ Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 10 years <u>Housewife</u> Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Levi Rice Margaret Hummer other traumatic 19a. Informant's Name/Relationship (Type, Print) uege 1 and 2 st. uepartment of Health an Important: If item 27 is r. any injury or other 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Williams daughter 42033 Betty Street, Gonzales, LA. 70737 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State December 1 \frak{M} Burial 2 $\frak{\square}$ Cremation 3 $\frak{\square}$ Removal from State 4 $\frak{\square}$ Donation 5 $\frak{\square}$ Other (Specify) cemetery, crematory or other place, Garrison Forest Owings Mills, MD. 2010 Signature of Fundral Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 23a. Part 1. Enter the disease, or complications that caused the death on one enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Each only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ ARTERY disease or condition resulting in death) DISEASE ORONARY Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate
cause (Disease or linjury Due to (or as a consequence of) Examin signed by the attending physician and deed detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Dav Year Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Records, DIABUTUR MOLITUS been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has performed' 1 Yes 2 No Yes 2 N 25. Was case referred to medica Division of Vital 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 ☐ No Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of s after death. Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident filled in by the Investigation Could not be 3 Suicide 4 Homicide Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 🗠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 7 only one) 29b. Signature and title of certifier P577 22 NOVEMBER 22 2010

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.P.

LEONANS RICHARDSON M.D. 1888 GREEPE TRUE RUAD \$ 300 PILLETVILLE MP 2120 8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}18 2<u>0</u>10 Physician/ 11:50AM NOVEMBER Sharon V. Lindsay Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Mar. 17 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** ^{Year)} 1949 Days Hours 1 M 2 F 216-56-4218 Yrs. **Director** Maryland Usual Residence of Decedent or 28a-f shov notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MDHarford Fallston 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? must be i Funeral 2709 Farmview Drive 21047 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 6 1 Never Married 2 X Married Completed by 1 Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ၉ Frank Brown other traumatic Verna Bussman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert S. Lindsay / husband 2709 Farmview Drive: Fallston. MD 21047 Important: If item : any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🗆 Cranation 3 🗀 Removal from State 4 Donation 5X other (Specify) entembrent Julaney Valley Mem Gardens 11/22/2010 Timonium. 21. Signature of Funeral S ov e Lice 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, MD 21204 23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause of aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ulma tubousn disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence or) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ♠ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 No 1 🗌 Yes 2 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tes Certificate: To 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 \(\subseteq \text{Yes} 5 Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 29b. Signature and title of certifier Cynthia Sniacro 10 11/18/2010 00057347 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CYN HM 9 SOLIAM MD 6701 N. CHAILES ST #530 TOWS ON W) 10 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

J DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	7	_	State of Maryland		artment of H tificate of D			201	0 36730
	·		Decedent's Name (First, Middle, Last)				2. Date of Dea		3. Time of Death
	Physicia Medic		Verthon leat				Month		Par F=15pM
	Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Death	1	4c. County of	Death
مجردر			worthwest Hapital		Ran-	BUSTO	un	1541	timore
	Funeral Director		5. Social Security Number 6. Sex 7. A de (In yrs. /as 1 🖾 2 18 – 34 – 1775 72	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		, Year) 1939	. Birthplace (State or Foreign Country) Maryland
			Usual Residence of Decedent				Jan 23	, 1939	Haryrand
	/land f sho ed at	ţċ	l (Town or Loc					10d. Inside City Limits
	Many 28a- notifie	irec	MD Baltimore	OWIN	gs Mills				1 ☐ Yes 2 🛣 No
	th the	Funeral Director	10e. Street and Number 9307 Groffs Mill Road		10f. Zip Code	1117		10g. Citizen of Wha	
	ath w	nue	11. Marital Status 12. Was Decedent Ever in U.S.	13. V			pecify Yes or No-		S.A. American Indian,
9	or ite	by F	Armed Forces? 1 Never Married 2 Married 1 X Yes 2 No		Vas Decedent of His FYes, specify Cubar		o Rican, etc.)		White, etc. White
<u> </u>	ırs afi ural", ILExa	Ped	3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates.	1	☐ Yes 2 🛣 No	Specify:		Specify:	WIIILE
2	"nat "nat	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	lent's Usual Occupa kind of work done d	ation Juring most of wor	rking	16b. Kind of Busin	ness Industry
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Q 2	led wi Hygid other ent, t	Be (17. Father's Name (First, Middle, Last)		Jares 1		me (First, Middle,	Maiden Surname)	
Baltimore, Maryland 21215-0036	l be fi fental rked tic ev	မ	Vernon Lamar Leaf, Sr.			Kath	erine An	thony	
ary	should be filed within 72 hours after death with the Maryland n and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at.		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	ig Address (Street a	and Number or Ru	ral Route Numbe	r, City or Town, State	e, Zip Code)
Σ	ealth m 27		Donna L. Bolte Sister	117 M	Mount Wils	son Lane	Pikesv	ille, MD	21208
ore	e 1 ar		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State	ace of Dispos metery, crem	sition (Name of natory or other place	e)	Date	20c. Location - Ci	ty or Town, State
Ē	t. Pag tmeni tant: njury o		4 □ Donation 5 □ Other (Specify) Ca		Cremation		13/2010	Hampste	
Ra	permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev		21. Signature of Funeral Stervice Licensee	- 1	. Name and Addres			isterstow stown, MI	
			23a. Part 1. Enter the disease, or complications that caused the death						Approximate
١,			shock, or heart failure. List only one cause on each line.					,	Interval Between Onset and Death
	Medical		Immediate Cause (Final disease or condition resulting in death) Due to (or as a cons x use	ence of):	CANDIAL	Arre	41		
	Examiner		Mes Icm di	11 1	Morris	401			
		Examiner	Sequentially list conditions, if any, backing to immediate cause. Enter Underlying	ance of):	7	7			
b	cuted ind transi	xam	Cause (Disease or iinjury that initiated events c.						
-	be executed sician and burial-transi	dical E	resulting in death) Last Due to (or as a conseque	since oi).					
9	r requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	edic	d						
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Box	eath e atter	icia	in the past 12 months? 1 Use Birth 2 Fetal 1 Pregnant at time of do		Ectopic pregnanc Other (specify)	У		Month	
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P.O.	s that gned se de	þ	Part II. Other significant conditions contributing to death but not resu	-	inderlying cause giv	en in Part I.			ute to the cause of death?
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S	law re has be e 2 sh	nple					24a. Was auto	psy pric	re autopsy findings available or to completion of cause of ath?
æ	The cate cate cate cate cate cate cate cat		25 M				1 🗆 Yes		Yes 2 No
ţ	sician certifi rector	Be (25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☑ Inpatient 2 ☐ I		LOthe	ace of Death (Che er:			
Division of Vital Records,	Physer this eral di	은: 10	27. Manner of Death 28a. Date of injury	28b. Time of			T.	dence 6 Other (Specify)
ž	nding ath. :: Afte e fune	Certificate:	1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation	injury	M 1 🗆	? Yes 2 \ No		,,	
SI	er des ector	ertif	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At hombuilding, etc. (Specify)		eet, factory, office	1	28f. Location (S		or Rural Route Number,
2	ital or irs aft al Dir led in	a C	Building, etc. (apocary)				Oity or 100	vii, State/	
	To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attencompleted filled in by the funeral director, page 2 should be detached for the completed filled in by the funeral director, page 2 should be detached for the funeral director, page 2 should be detached for the funeral director.	edical	29a. Certifier (Check 2 Medical Examiner: On the best of my knowle	and/or invest	tigation, in my opinio	on, death occurred	at the time, date a	and place, and due to	the cause(s) and manner stated.
	the lithin 2 the lomple	ž	only one) 3 Certifying Nurse Practioner: To the best of my 29b. Signature and title of certifier	knowledge, o	death occurred at the		ace, and due to the	e cause(s) and mann 29d. Date signed (f)	· · · · · · · · · · · · · · · · · · ·
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			30. Name and address of person who completed cause of death (Item	23a) (Type. F	Print)	1/14		NUWNBR	2/1,50/0
	19		Alike 1-15/10/ 540/010	100.	wit B	and Ren	adalls to	Inn Inc	nipland
	Sta		31. Date filed (Month, Pay Year) Server 32. Regigirar's Signat	The I		THE LEVEL			,
	Registra	ar	MAN TO TOUR VOICE						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 2010 ANNA MAY LINDSAY рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Assisted Living Well Millersville Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yo August 27, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🗶 F Mary Land Director 212-28-2333 93 Usual Residence of Deceden if of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Maryland Anne Arundel Brooklyn Park 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 403 Waverly Avenue 21225 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ģ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William G. Carneal Anna Eades 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Betty J. Butler (Daughter) 15th Avenue, Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔊 Burial 2 🗆 Cremation 3 🗆 Removal from State Glen Haven Mem. Park injury (4 ☐ Donation 5 ☐ Other (Specify) Nov.24, 2010 Glen Burnie, Maryland Signature of Funeral ervice Licen 22. Name and Address of Facility McCully—Polyniak Funeral Home P.A. 237 East Patapsco Avenue, Baltimore, Maryland 21225 22. Name and Address of Facility 23a. P. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, h.ck, or heart failure. List only one cause on each line. Is modiate Cause (Final discrete or condition resulting in death) Onset and Death end stage Physiciani cardiac Medical Due to (or as a consequence of): Examiner to Sequentially list conditions, if any, leading to immediate Examine Cause (Disease or iinjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death Unknown 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No ☐ Yes 1 Tes To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Assisted Hospital Other: 4 Nursing Home 5 Residence 6 Other (Sp. Living 1 ☐ Yes 2 ☒ No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined 24 hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3× Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) and title of certifi License number 29d. Date signed (Month, Day, Year) 1086053 11-22-2010 ane 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) Sevene Park MD 21146 213 Newport Dr 015 Jane Schramek CKNP 31. Date filed (Manth, Day, Year) 32. Registrar's Signature 60 CU Registrar

A DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2010 Physician/ November 2:21 William C. Morgan Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Prince George's 12304 Melling Lane Bowie If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** (Month, Day 5ex 1 ፟፟፟ M 2 ☐ F Days Hours Min. Pennsylvania 78 Yrs. **Director** <u> 161-26-9219</u> Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State Examiner must be notified at should be filed within 72 hours after death with the Maryland Director 1 Yes 2 XNo 28a-f Prince George's Bowie Maryland 10f. Zip Code 10g. Citizen of What Country? ö 10e. Street and Number Funeral items 23a USA 20715 12304 Melling Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 \(\text{No.} \) No. 1954

If Yes, Give 1057 Black, White, etc. 0. þ 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 1.957 "natural", Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Meatal once. (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Self Employed Attorney Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Mary Caswell David R. Morgan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12304 Melling Lane Bowie, Maryland 20715 Irmgard H. Morgan, Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore, Maryland Metro Crematory Inc. 11/22/10 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complicators that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final enal Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter through a Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed line of the Innerial director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of deliven 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No
9 Unknown Month Year Dav Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 🗀 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Hospital: Other: 2 No 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No injury 1 Natural 5 Pending Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 51169 22 2010 MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Konni Bringman MD 4201 Mitchellville Road Suite 102 Bowie, MD 20716

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

31. Date filed (Month, Day, Year) 32. Registrar's Signature 2010

23

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OUT mo Medical 4a. Facility Name (if not institution, give street 4b. City, Town **Examiner** County of Death K If Under 24 Hrs. 8. Date of Birt **Funeral** . Age (In vrs. last birthday 9. Birthplace (State or Foreign Months Mir **Director** iral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Monk 1 🗆 Yes 2 💢 No 10e. Street and Number 10g. Citizen of What Country? Funeral Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 W No If Yes, Give Year or Dates. 11. Marital Status 12. Was 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) School (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) chool Be Father's Name (First, Middle, Last) မ other traumatic 19b. Mailing Address (Street and Number or Rural Route Number Baltimore, 20a. Method of Disposition
1 □ Burial 2 ☑ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other Department of Important: If it any injury or c of Funeral Service Lice 22. Name and Address of Facility (47Z 23a. Part 1. Enter the disease, of shock, or heart failure. List eath. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Ones and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a cons uence of): Examiner Sequentially list conditions, if any, leading to immediate the best of the cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) resulting in death) Last ate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Day Year Pregnant at time of death 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown No 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy To the Funeral Director: After this certificate of completed filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State) within 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) Mark Camoi 13452 11-22-10 Mark Lamos MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road 109

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day

NOV 23 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 20.30 PM 2010 Margaret E. Miller 20 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore Hospita If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Y July 19, 6. Sex 9. Birthplace (State or Foreign Year) 1952 **Funeral** Days Months Hours 1 □ M 2 🕏 F Maryland Director 219-58-3786 58 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, I'm Medical Examination must be notified at Director 1 ☐ Yes 2 ☑ No Carrol1 Sykesville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 2029 Sherryl Avenue 21784 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married Specify: White 1 □Yes 2 No Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) parmit. Pages 1 and 2 should be filed with Dapartment of Health and Mental Hygien Important; If Item 27 is marked other the any Injury or other traumasts. <u>Medical Tr</u>anscriptionist Medical 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy Dabkowski James T. Boilon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles W. Miller, Jr. Husband 2029 Sherryl Avenue; Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Sykesville, MD Lake View Mem. Park 11/23/2010 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Lice 1630 Edmondson Avenue: Catons not enter the mode of dying, such as cardiac or respiratory arrest, 1630 Edmondson Avenue: Catonsville, MD 21228 Part / Enter the disease, or co / lications in t cause (the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 3 day. -u/minant disease or condition resulting in death) /Medical Due to (or as a consequence of): Youths Examiner liver Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Vears Colon Cancer Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ ₩0 Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ੬ Cancer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1 □ Yes 2 ♣ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Iniury 5 Pending

ba executac burial-tran attending physician for use as tha buria 68760 law requiras that tha death certificate Box o Aftar this certificate has been signed by the funeral director, page 2 should be detached Miller, Margaret σ. Records, Hospital or Attending Physician: The 124 hours aftar death. Funeral Director: Aftar this certificate ha stely filled in by the funeral director, page Vital ð

Division

natural", or items 23a

72 hours after

Baltimore, Maryland 21215-0036

1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

Medical

4 Homicide

1 🗹 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

BELLEV

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900 S. Caton

32. Registrar's Signature

State Registrar

24 hours a

within 2

completely

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 04 08 AM John Eugene McNulty 18 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Aug. 20 | 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year 1920 Scranton, PA 179-16-0139 90 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location fshow permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it. Medical Expr. in act to purify du once. 1 ☐Yes 2 No Director MD Baltimore Catonsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2211 Rockwell Avenue 21228 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 □Yes 2 □XNo Specify: White Specify. 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) City of Scranton Fire Fighter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Patrick J. McNulty Bridget Duffy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne McNulty/Daughter 2211 Rockwell Avenue; Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🖾 Removal from State Cathedral Cemetery 11-23-2010 Scranton, PA 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Signature of Funeral Service Licensee 1630 Edmondson Avenue; Catonsville 23a. Part I. Enter the disease, of complications that caused the death. Shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEP IIC SHOCK **Physician** (UTI) Days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner RENAL Sequentially list conditions Examine in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events signed by the attending physician and be detached for use as the burial-transi COROARY ARTERY resulting in death) Last Due to (or as a consequence of): O. Box 68760, HYPERTENSION 1 E4 B1 Physician/Medical JOH IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 0 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ≥ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown To the Hospital or Attending Physician: The law requir within 24 hours after death.
To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Vital 2 No 1 ☐ Yes 2 PNo 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Nnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifer 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

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CATON AVE BALTIMORE

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For
State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Month V 1000 'UD PM Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 14000 (oer 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country 1 🗆 M 2 💢 Months Days Hours Min. (Month, Day, Year) Jun 22, 1931 578-52-7580 79 Director Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring MD Montgomery 1 🗆 Yes 🏞 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 20905 15109 Hildegard Ln U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Bace - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married 2**%** No ___ Yes Baltimore, Maryland 21215-0036 1 🗆 Yes 2 No If Yes, Give Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **Adminsitrative Secretary** Clerical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Percival Roche lvy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Moon 15109 Hildegard Ln Silver Spring, MD 20905 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other p Atlantic Crematory, LLC Nov 19, 2010 Glen Burnie, MD 4 Donatio 5 Other (Specify) 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 Funeral Service D1293 23a. Part 1. Enter the disease are complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Jnevnonio Physician disease or condition resulting in death) reek Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or impury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has autopsy performed Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred injury 1 🗖 Natural 5 Pending 2 🗌 No Accident Investigation s after death 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined he Funeral D Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сотрете Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29d. Date signed (Month, Day, Year) D46120 ss of person who completed cause of death (Item 23a) (Type, Print) 30_Name and addre dunsia 00 ê /00L 10/710 Charte 31. Date filed (Month, Day, Year) ₱32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ILLER Physician/ 8:00 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death COLSTON SILVER SPRING MONTGOMERY Social Security Number 226-76-0456 7. Age (In yrs. last birthday)
79 Yrs. 8. Date of Birth (Month, Day, 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F Country) Director France Usual Residence of Decedent 23a or 28a-f show 10a. State MD 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Montgomery "natural", or items 23a or 28a-f s edical Examiner must be notified Silver Spring 1 🔀 Yes 2 🗌 No 10f. Zip Code 10g. Citizen of What Country? 2201 Colston Dr. #809 20910 Funeral USA death with 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces? 1 ☐ Yes 2 🖺 No permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinane. 1 Never Married 2 Married Black, White, etc. Completed by Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: If Yes, Give 3 - Widowed 4 - Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Biochemist Research Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Sophia Rozak Edouard Berberian ဂ္ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roger W. Miller / Spouse 2201 Colston Dr. #809, Silver Spring, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 11/20/2010 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crem. Woodbine, MD 21. Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility Maryland PO Box 1 Services remation 3. Balti mai su 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Immediate Cause (Final Lung Cancer 6 Months Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of impury that initiated events Examine Due to (or as a consequence of): that the death certificate be executed burial-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Live Birth 2 Live Grant Pregnant at time of death Dav 9 🗌 Unknown g Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlyi*n*g cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension Hospital or Attending Physician: The law requires 24 hours after death. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 1 ☐ Yes 2 ☐ No Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🗷 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No. 2 Accident
3 Suicide Investigation within 24 hours after deati To the Funeral Director; completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) 29a. Certifier **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Gertifying Nurse Practioner: To the best of my knowledg at the time, date and place, and due to the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

NOV 23 2010

32. Registrar's Signature

D28656

rs of person who completed cause of death (tem 23a) Gype, Brint)
Passo, M.D., 15245 Shady Grove Rd., #130, Rockville, MD 20850

11/18/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 18 2010 Miguel 1444 PM Α. Moreno Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Rockville Shady Grove Adventist Hospita Montgomer Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 215-27-5061 Country) Chile 1 X M 2 X F 70 Director 12/22/1939 Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Gaithersburg 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 405 Funeral W. Diamond Avenue, 203 20877 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 XNo If Yes, Give Baltimore, Maryland 21215-0036 tX Yes 2 □ No SpecifyChilean White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 4 Cook Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Antonio Moreno Elena Campos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Carolina Moreno/Daughter 9934 Shelburne Terr., #408, Gaithersburg, MD 20878 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Final Journey Crem. 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 11/23/2010 4 Donation 5 Other (Specify) Woodbine, MD 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21. Signature of Funeral Service Licensee Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ardiac disease or condition Medical resulting in death) **Examiner** Spiratory Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury -transit Hospital or Attending Physician: The law requires that the death certificate be executed Intracerebra and that initiated events Due to (or as a consequence of resulting in death) Last burialattending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Failure 1 Yes 2 No 3 Probably 4 Punknown Obstructive Pulmonary 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has page perform 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No s after death. 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined within 24 hours a

To the Funeral D Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier Melaci D0064418 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) for Rockville, mb 20850 agoi medical Cfr. Mehari MD 32. Registrar Signat State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_	For State Registrar	State of M	aryland		artment o					36739
			Decedent's Name (First, Middle	le, Last)	-			or Dodin	<u> </u>	2. Date of Death	eg. No.	3. Time of Death
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	Medic Examin		4a. Facility Name (if not institution		HOI.	LISUII	4b. City, Tov	n or Locatio	on of Death	Novembe	4c. County of Dea	
/	Examin	er			T 22-		1		on or Death			
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	Director		217-28-2709	1 □ M 2 🛛 F	77	Yrs.		ays Hour		Aug 19,	Year 933	Maryland
			Usual Residence of Decedent		,,					1108 17,		
	and shov	ō	10a. State 10b. County	У	10c. City,	Town or Loc	cation				-	10d. Inside City Limits
	Aaryl Ba-f tified	Director	Maryland Bai	ltimore		Timon	ium					1 ☐ Yes 2 🛛 No
	or 2	ا ق	10e. Street and Number	2 2 2 2 2 2		I IMOII	10f. Zip Co	de		-1	0g. Citizen of What C	ountry?
	with sta	Funeral	12261 Roundwo	od Road				1093			USA	
	tems er m	Fu	11. Marital Status	12. Was Decedent 8	Ever in U.S.	13. V			Origin? (Spe	ecify Yes or No- Rican, etc.)	14. Race - Am	erican Indian,
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L	within 72 hours after death with the Maryland glene: et than "natural", or items 23a or 28a-f sho t, the Medical Examiner must be notified at t, the Medical Examiner must be notified at	Completed		ent's Education nest grade completed)		16a. Deced	lent's Usual D kind of work d	ccupation	acet of work	ina	16b. Kind of Business	Industry
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<u>X</u>	id be Meni arke atic	욘	Gerald	Dennis	Hi	11		_ I	ndia		Purcell	
ā	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mentel Hygiene. If health and Mentel Hygiene. Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Me lical Examiner must be notified at	- 3	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailir	ng Address (St	reet and Nur	nber or Rura	l Route Number,	City or Town, State, Z	ip Code)
≥	and 2 s Health tem 27		Andrew A. Mor	rison/Son		206	Tufts F	Road,	Timoni	um, Mary	yland 210	93
Sec			20a. Method of Disposition 1	2 Dameual from State		ace of Dispo	sition (Name o	of r place)		Date	20c. Location - City o	r Town, State
Ĕ	Page 1 ment of ant: If it ury or o		4 Donation 5 Other		1		ge Cem		11/2	0/10	Pikesville	e, Maryland
Baltimore, Maryland 21215-0036	permit. Page Department of Important: If any injury or once.	- 1	21 Signature of Europe Service	Lingsfeel	-	22	. Name and A	ddress of Fa	cility			
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			23a. Part 1. Er er the lisease, o	or complications that caused	the death.							Approximate
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J	xecu n and al-tra		that initiated events resulting in death) Last	Due to (or as	a conseque	ence of):						*
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9/	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical										
Box 687	certif nding use a	<u>\</u>	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnan	ісу	7				23d, Date of de	eliverv
ŏ	atte	icia	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 Live Birth 4 Pregnant a			Ectopic preg Other (speci				Month	Day Year
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P.O.	requires that the des been signed by the s should be detached	by P	Part II. Other significant condit	ions contributing to death b	out not resu	llting in the u	nd e rlyin <i>g</i> caus	se given in P	art I.	23e. Did tob	acco use contribute t	o the cause of death?
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Division of Vital Records,	Phys this raldi	. To	27. Manner of Death	1 ∐ Inpati 28a. Date of inju		R/Outpatier 28b. Time of	1 3 DOA	Injury at		me 5 Reside 28d. Describe how	nce 6 Other (Spe	cify)
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Ξ	or A after Dire	Sel	4 Homicide deter	mined building, etc		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	or, ractory, or	1100		City or Town,		urai noble Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	ca	29a. Certifier 1 Certifyin	ng Physician: To the best of	my knowle	edge, death	occured at the	time date a	nd place an	d due to the caus	se(s) and manner se st	tated
	Hos 24 h Fur eted	Medical	(Check 2 \(\subseteq \text{Medical} \)	Examiner: On the basis of e	examination	and/or invest	tigation, in my	opinion, death	h occurred at	the time, date and	d place, and due to the	cause(s) and manner stated.
	o the	2	only one) 3 L Certifyin 29b. Signature and title of certifie	ng Nurse Practioner: To the er	Dear OF ITTY	A lowledge, (ense numbe			cause(s) and manner a 9d. Date signed (Mon:	
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	Stat	0	David P. Boer 31. Date filed (Month, Day, Year)	sma, MD /505	ar's Signatu	er Dri ure	ve, su	rte 21	LU, TO	wson, Ma	ryland 2	1204
	Registra		NOV 2 3 2010	Beneva D.	bar	Kar						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Bernard Maker November 2010 10:25AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 1817 Arunah Avenue Baltimore 9. Birthplace (State or Foreign Country) Maryland Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth **Funeral** Hours 1 X M 2 □ F 212-24-9494 Director 82 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Examiner must be notified at Director 1 X Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? or items 23a 1817 Arunah Avenue 21217 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc. 1 Never Married 2 Married Completed by Yes 2 X No Yes, Give 72 hours after 1 Yes 2 X No Specify: "natural", 3 Widowed 4 X Divorced Year or Dates Black injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Megonee. nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Warehouse Packager Manufacturing Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert Maker Mabel Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Collette Elliott / Daughter Wyanoke Avenue, #513, Baltimore, MD 21218 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Anatomy Gifts Registry 11/23/2010 Hanover, Maryland 4 ☑ Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 21. Signature of Funeral pervice Licenses 22. Name and Address of Facility 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Dust follows a nonsequence of Many leading to immediate cause. Enter Underlying Examin Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? the Hospital or Attending Physician: The law requires that the death Pregnant at time of death Unknown 2 No g Unknown Division of Vital Records, P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page certificate I 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 X No မြ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accident 3 Suicide work?
1 Yes 2 No injury 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one Signature and title 29c. License number 18/5010 person who completed cause of death (Item 23a) (Type, Print) 2300 JONES

State Registrar

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Amanda Montgomery Medical $1:50p^{M}$ November 201 4a. Facility Name (if not institution, give street and number)
Greater Baltimore Medical Cente 4b. City, Town, or Location of Death TOWSON Examiner 4c. County of Death Baltimore 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F Hours 90 1/M9/19/1. Peg2(Year) 216-19-4466 MD Director Usual Residence of Decedent 23a or 28a-f show ast be notified at 10a. State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Baltimore Pikesville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7425 Ricksway 21208 USA or items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces? Black White, etc þ 1 Never Married 2 Married and 2 should be filed within 72 hours after thealth and Mental Hygiene. Health and Mental Hygiene. Sem 27 is marked other than "natural", or 1 ☐ Yes 2 No Specify: If Yes, Give 3 - Widowed 4 - Divorced Specify: African-American Completed Year or Dates event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Housewife Damestic Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Wilbert Presbury Edna Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edna R. Montgamery/Daughter 7425 Ricksway Road, Pikesville, Md 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory 20c. Location - City or Town, State 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-27-2010 Baltimore, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 Part Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ SCHEMI disease or condition resulting in death) 1CALS Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine pue to for as a consequence of signed by the attending physician and doe detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Yes 2 Pregnant at time of death Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by or Attending Physician: The law requires PERTENS 1 Yes 2 No 3 Probably 4 Unknown ron 10 Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy death? After this certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) 2 No ည 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 🗌 No Accident Investigation Could not be Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hox To the Fune completed fi (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified 100 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID SALT. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	State of Ma	arylan	-		nt of H te of C		Mental H		2010	36712		
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	Examin	er	4a. Facility Name (if not institution, give s 10500 Rockville E		7		4b. City, Town, or Location of Death Rockville					4c. County of Death Montgomery			
	Funeral		5. Social Security Number 6. Sec	7. Age		as <i>t birthday)</i>	If Under 1 Year If Under 24 Hrs. 8, Date of B				irth 9. Birthplace (State or Foreign				
	Director		579-68-2246 1 L	_ M 2 🛛 F	96	Yrs.	Months	Days	Hours Wi	0ctobe	er 28	,1914 Col	ombia		
	and show	ror	10a. State 10b. County		10c. City	y, Town or Loc	cation						10d. Inside City Limits		
	Mary 28a-f otifie	Director	Maryland Montgo	mery		Ro	ckvi						1 ☐ Yes 2 X No		
	vith the 23a or st be r	ralD	10e. Street and Number 10500 Rockville E	Pike. #162	2.7		10f. Z	ip Code	20852		10g. Citizen of What Country? United States				
	leath v items er mu	Funeral		12. Was Decedent E Armed Forces?		S. 13. V	Vas Dece	edent of His		(Specify Yes or No		14. Race - Amer	ican Indian,		
36	after c	d by	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🏋 If Yes, Give	No		13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ■ Yes 2 □ No Specify: Colombian					Black, White			
9500-61212	hours nature lical E	Completed	Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working)								16b.	Kind of Business I			
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Maryland	should and Iv is me rauma		19a. Informant's Name/Relationship (Typ				-					or Town, State, Zip	·		
ē,	and 2 Health tem 2		Mario Mendoza / 20a. Method of Disposition	Son	20b. P	14402 Place of Dispos					_	Maryland Location - City or			
ē	Page 1 nent of int: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ 9 4 ☐ Donation 5 ☒ Other (Specify	Removal from State Entombment	C	emetery, crem e of Hear	natory`or	other place		vember , 2010	1	ver Spring			
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	() (2)	21. Signature of Funer Service License		1305	Ro 30	Name a bert 0 Wes	nd Addres A. Pun			/Roci	kville, Ind	d 20850–2805		
			23a. Part 1: Enter the disease, or complishock, or heart failure. List only on	lications that caused e cause on each line	the deat								Approximate Interval Between		
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л. О	s that gned be deta	by	Part II. Other significant conditions co Failure to Thrive		ut not res	ulting in the u	nderlying	cause giv	en in Part I.				the cause of death?		
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	To th within To th	_	29b. Signature and title of certifier	71	_			c. License	number	,,	29d. D	ate signed (Month	, Day, Year)		
				fund	mi			D005	55522		N	ovember :	22, 2010		
)			30. Name and address of person who co Robert H. Gerard,					Road	, Silve	r Spring	, Ma	ryland 2	0910		
	Stat Registra		31. Date filed (Month, Day, Year) NOV 2 3 2010	32. Registre	r's Signat					. 0					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 George Richard Miller P M November 2:45 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Renaissance Gardens Silver Spring Prince George's Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XXM 2 □ F Months Davs Hours Min. Feb. 21 1919 Country) Director 299-03-7603 91 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Montgomery Silver Spring MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3160 Gracefield Road 20904 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 1. Marital Status Race - American Indian. Armed Forces?
1 ☐ Yes 2XXNo Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 XNo Specify: White Completed 3 X Widowed 4 □ Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Draftsman Aerospace Ве 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul C. Miller Hanora Flanagan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail Kostas/daughter 7505 Haines Ct, Laurel, MD 20707 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arundel 11/24/2010 Crematory : Odenton, MD 21. Signature of Funeral Service Lic 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01581 313 Talbott Avenue, Laurel 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Arteriosclerotic coronary artery disease disease or condition resulting in death) Unknown Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Day Other (specify) Pregnant at time of death 2 No g Unknown the 9 Unknown n signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Advanced dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐XUnknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 X certificate | within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, to Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 Residence 6 Other (Specify) မ 2**/X**No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide City or Town, State) Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 3 Sertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier License number

12 State

Registrar DHMH 17 Rev 7/2009 Silver Spring, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3160 Gracefield Rd,

Signature

Eileen Gemnell

31. Date filed (Month, Day, Year)

23

29d. Date signed (Month, Day, Year)

20904

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month JOSEPH J. MARCIN, JR. NOVEMBER 3:00 P. 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1503 DELLSWAY ROAD BALTIMORE TOWSON 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours Country)
MARYLAND 219-28-6021 Yrs. Director /20/1933 Usual Residence of Decedent 28a-f shov 10a. State iral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE TOWSON 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1503 DELLSWAY ROAD 21286 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 X Yes 2 ☐ No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: "natural", 3 XWidowed 4 Divorced Completed Year or Dates. KOREAN WHITE traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) PHONE COMPANY ENGINEER 12TH GRADE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental မ JOSEPH J. MARCIN, SR. MARIE SCHEUERMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trau WILLIAM D. MARCIN/SON 84<u>15 MACAULEY CT.</u> LUTHERVILLE-TIMONIUM, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 11/24/2010 PARKWOOD CEMETERY BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. MO0217 LOCH RAVEN BLVD TOWSON. MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ MYOCARDIAL Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of). Exami or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician Physician/Medical Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death Yes 2 No the 9 Unknown g Unknown P.0. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 K Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a, Was an has autopsy performed?

1 Yes 2 No certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 ANO မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: To the Funeral Director: After i completed filled in by the funera 28d. Describe how injury occurred 1 🔼 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral C Hospital Medical 29a. Certifier 🖺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 25047625 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) eath (Item 23a) (Type, Print)
9600 OSUAZ Print, Slife 311. TOWSON, MO Z1204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

			1 - State of Maryla Registrar		artment of H tificate of L		-	giene Reg. No.	36745
	Dhusisis	-/	1. Decedent's Name (First, Middle, Last) Maria Agnes				2. Date of De	ath	3. Time of Death
	Physicia Medic	al		V 3			Novim		10 9 7
	Examin	er	4a. Facility Name (if not institution, give street and number) NONTHWEST HOSPITAL G	N 451_	4b. City, Town, or			4c. County of D	i mere
_	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 2	4 Hrs. 8. Date of Bir	th 9.	Birthplace (State or Foreign
	Director		218-28-3242 1 □ M 2 🖾 F 87	Yrs.	WIOTHIS Days	Hours	Dec 16	y, Year) 1922	Holland
	and show	or	Usual Residence of Decedent 10a. State 10b. County 10c. C	ity, Town or Loc	cation				10d. Inside City Limits
	Maryla 28a-f	Director	MD Baltimore	Reis	sterstown				1 ☐ Yes 2 🌠 No
	3a or	al D	10e. Street and Number		10f. Zip Code			10g. Citizen of What	
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er the Medical Examiner must be notified at	Funeral	306 Cantata Court, Apt 320 11. Marital Status 12. Was Decedent Ever in U	S 13 \		1136	in? (Specify Yes or No-	USA	merican Indian,
ဖွ	ter des	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No	H	f Yes, specify Cuba	n, Mexican,	Puerto Rican, etc.)		hite, etc.
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Maryland	should be and Men is marke raumatic	1	Johamer Fransicus	Aarts			ertina		Heuts
<u>⊠</u>	2 shou Ith and 27 is m traum		19a. Informant's Name/Relationship (Type, Print) Charles F. Matthews Son				or Rural Route Numbe		erstown, MD
ē,	of Heal of Heal fitem ;		20a. Method of Disposition 20b.	Place of Dispos	sition (Name of natory or other place		Date	20c. Location - City	
<u>E</u>	Page ment o ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ga:		Forest Ve	1 1	1-30-2010	Owings	s Mills, MD
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signat ve f Fun va Service Licensee		. Name and Addres		1102	Reisters	
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Box	requires that the death certific been signed by the attending should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Live Birth 2 Live Birth 1 Live Birth 2 Live	tal death 3	Ectopic pregnand Other (specify)	У		23d. Date of Month	delivery Day Year
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<u> </u>	I or Attending Physician: The law after death. Director: After this certificate has Jin by the funeral director, page 2		ATLIAL FIBRILIATION 25. Was case referred to medical		26 DI	oo of Dooth	1 Yes		Yes 2 No
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	To the Hospital or A within 24 hours after To the Funeral Dire completed filled in b	edical	29a. Certifier 1 Certifying Physician: To the best of my know	vledge, death o	occured at the time,	date and pl	ace, and due to the ca	use(s) and manner as	stated.
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			30. Name and address of person who completed cause of death (Itel	m 23a) (Type P	rint)	130,	NORTHNOCE	T Ham	12 12, 2010
	le		ORIANDO B. CONGNAU	nd		24	NOACISTON	on non	72 15, 2010 TAL GOVERN
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death **Baltimore** Parkville Oak Crest Care Center 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In vrs. last birthday) if Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Min. Hours 2/6/1918 Year) Mary Tand 92 219-03-6991 Director Usual Residence of Decedent of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 X No **Baltimore** Parkville Mary land 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21234 8800 Walther Blvd # 3308 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces? 1 ☐ Yes 2 🗷 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Completed by 1 Never Married 2 X Married 1 Yes : Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Electrical Engineer BG&E Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ should be Katharine Mary Mueller Thomas Franklin Meyers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy E. Meyers / Wife Page 1 and 2 8800 Walther Blvd # 3308 Parkville, Maryland 21234 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Vailey Mem Gardens 11/27/2010 permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State 1 🗶 Burial 2 🗆 Cremation 3 🗆 Removal from State Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician; T e law equires that the death certificate be executed e has keen signed by the attending physician and ge 2 should be detached for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box (3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day 5 Other (specify) 1 Yes 2 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an certifica e has autopsy Thomas completed filled in by the funeral director, p 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work? 5 Pending Accident Investigation ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital 24 hours a Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 H within 2 To the I 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 21 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM 31. Date filed (Month, Day, Year) NOV 2 3 2010 32. Registrar's Signature State Registrar

9

Mayers

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12, 2010 November Lloyd W. Mitchell 3:15 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Oak Crest Village **Baltimore** Parkville Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Date of Birth 1 **M** M 2 □ F Months Days Hours Min. 9/30/14 Year) Mary Land **Director** 219-01-5154 96 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Mediral Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Baltimore Parkville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8834 Walther Blvd. 21234 **RGN333** USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married δ 1 Yes 2 No If Yes, Give Specify: Completed Specify: Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry
Maryland School (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) for the Blind 12 <u>Teacher</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Mitchell Florence Mitchell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Laurence Mitchell / 603 Trout Dale Terrance Belair, Maryland 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🌠 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 11/17/10 Baltimore, Maryland 21. Signature of Funeral Service Licers 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Debility Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Dementia Multi-Infarct Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Dav Year eral Director: After this certificate has been signed by the filled in by the funeral director, page 2 should be detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 21 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 11 Natural 1 Yes 2 No Accident Investigation 24 hours after deatl 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the I only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated and title of certifier 29b. Signatu 29d. Date signed (Month, Day, Year) 2010 R171944 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8800 Walther Blad, Parkville MO 21234 Michealle G Harryon CRAP

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

NOV 23 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State o	of Maryla		artment of tificate of	Health and	Mental Hy	0.0		36748
			Registrar 1. Decedent's Name (First, Middle	, Last)			timouto or	Boatin	2. Date of De	Reg. No.	i	3. Time of Death
	Physicia		MIKHAIL	MAY	75111	38.R.G			Month Noveme	Day	Year 2.010	12:22PM
	Medic Examin		4a. Facility Name (if not institution			32.0	4b. City, Town, o	or Location of Deat	10000	4c. County		
			SINAI HOSPITA	L OF BA	LTIMO	ORE	BALT	IMORE	CITY	N	I/A	
	Funeral		5. Social Security Number	6. Sex		s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs	8. Date of Bir			lace (State or Foreign
	Director		213-35-2453	1 ∏ M 2 □ F	9	O Yrs.	Months Days	Hours Will.	10/12/	1920	Count	''' UKRAINE
	ld sow	_	Usual Residence of Decedent 10a. State 10b. County		100	City, Town or Loc	ration				1/	0d. Inside City Limits
	arylar a-f st	Director									'	1 X Yes 2 □ No
	or 28s	Dire	MD N/A 10e. Street and Number			BALTIMO	10f. Zip Code		1	10g. Citizen of	Mhat Coun	
	vith the 23a c	rai	6810 PARK HEI	THTS AVEN	IIF #2	02	2121	5		USA	VVII at Oodin	uy:
	ems r mu	Funeral	11. Marital Status	12. Was Dece				Hispanic Origin? (S	pecify Yes or No-		e - America	an Indian.
9	2 hours after death with the Maryland "natural", or items 23a or 28a-f show idical Examiner must be notified at.	by F	1 Never Married 2 X Mar	ried Armed Fo	2 🗓 No			an, Mexican, Puert	o Rican, etc.)		ck, White, e	
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Maryland	nould be filed within 72 hours ind Mental Hygiene. s marked other than "natura umatic event, the Medical E.	힏	ABRAHAM		MAYZ	ENBERG		GITTEI		maidell darrain	zazui	LIA
аZ	1 and 2 should be of Health and Ment item 27 is marked other traumatic e		19a. Informant's Name/Relations	nip (Type, Print)			a Address (Stree	t and Number or Ru	ıral Route Numbe	er. City or Town, S		
	d 2 st alth a 27 is or tra		DINA MAYZENBE	RG/WIFE		6810	PARK HEI	GHTS AVEN	NUE, #20	2, BALTI	MORE,	, MD 21215
ē,	1 and of He ritem		20a. Method of Disposition			. Place of Dispo	sition (Name of natory or other pla	200)	Date	20c. Location	- City or To	wn, State
Ĕ	Page 1 nent of ant: If ii ury or o		1 □XBurial 2 □ Cremation 4 □ Donation 5 □ Other (\$		State BE			PARK 11/2	21/2010	RANDA	ALLSTO	OWN, MD
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature Funeral Service I	icensee			Name and Addr	ess of Facility STERSTOWN		NSON & I		
			23a. Part 1. Enter the disease, or	complications that	N caused the de						ء وتلتك	Approximate
	hysician/		shock, or heart failure. List of Immediate Cause (Final			m / :	^					Interval Between
	Medical		disease or condition resulting in death)	a. Due to	or as a cons	equence of):	17					3 DAYS
	Examiner		Convention, that conditions	isch	EMIL	STRIK	E WITH	, Hemo	RRHAGI	C CONVE	RSION	4DAXS
	_ +	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(or as a cons	equence oi):						
	cutec	xarr	Cause (Disease or iinjury that initiated events	C. — Due to	(or as a cons	anuana afi						
_	ate be executed physician and the burial-transit	alE	resulting in death) Last	Due to	(Or as a cons	equence on.						
09/	cate b physi the b	edical		d								
ဆွ	The law requires that the death certific attends been signed by the attending page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou						23d Da	ate of delive	arv .
Вох	eath c atter	icia	in the past 12 months?	4 🔲 Preg	nant at time		Ectopic pregnar Other (specify)	ncy				Day Year
). E	the d by the acher	hys	9 Unknown	9 🗌 Unk	nown							
P.O.	s that gned I	by F	Part II. Other significant condition		leath but not	resulting in the u	nderlying cause o	given in Part I.		/		e cause of death?
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CO	aw re las be	Completed							24a. Was	psy	prior to cor	osy findings available ripletion of cause of
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ta	ician: certifi ector,	Be	25. Was case referred to medical examiner?	Hospital:			70.4	Place of Death (Che	eck only one)			
<u>-</u>	Phys this ral dir	2	1 Yes 2 No 27. Manner of Death	28a. Date		ER/Outpatier	IL 3 LI DOA		T	dence 6 Oth)
0	ding th. After fune	cate	1 ☑ Natural 5 ☐ Pendii 2 ☐ Accident Investi	ng (Mor	nth, Day, Year)	injury	wo	rk? ☐ Yes 2 ☐ No	26d. Describe	how injury occur	rea	
<u>sio</u>	Atten	Certificate:	3 Suicide 6 Could 4 Homicide detern	not be 28e. Place			eet, factory, office			Street and Numb	er or Rural	Route Number,
Division of Vital Records,	tal or rs afte al Dir			build	ing, etc. (Spe	city)			City or To	vn, State)		
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2 seminary.	Medical	(Check 2 ∐ Medical I	Physician: To the laxaminer: On the ba	sis of examina	tion and/or inves	tigation, in my opir	nion, death occurred	at the time, date	and place, and du	ie to the cau	use(s) and manner stated.
	o the vithin o the complex com	Σ	only one) 3 L Certifying 29b. Signature and title of certifie	Nurse Practioner:	10 the best of	my knowleage, o		se number	lace, and due to ti	29d. Date signe		
			David	11110	b		RE	5 - 00				
	7		30. Name and address of person	who completed cau	se of death (I	tem 23a) (Type, F	Print)			IVOV CITT	e chi_	10,2010
					nD	51	NAI	HUSPITI	7L 07	BA	LTIN	18,2010
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician/ OVEMBER 03:40 AM Neser erome Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City: Town, or Location of Death Examiner JOHNS HOPEINS BAYVIEW MEDICAL GETTER BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** March 12 1 X M 2 - F Months Hours Mary land 90 220-09-4008 Director Usual Residence of Decedent 10b. County 10c. City. Town or Location 10a. State Funeral Director 1 Yes 2 X No 28a-f Maryland Baltimore Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5 ms 23a or 8017 Bank St. 21224 USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian. 11. Marital Status Black, White, etc. ud Mental Hygiene. marked other than "natural", or i matic event, the Medical Examin Completed by 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give Year or Dates. W altimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: White 3 X Widowed 4 Divorced WW II 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Forklift Operator American Can Company Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) th and Mental F ည Ρ. Cyri1 Neser Lottie Μ. Emerick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other traconce. Jerome F. Neser, Jr. (Son) 8017 Bank St., Baltimore, MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Loudon Park Cemetery 11/24/10 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licens 3620 Wilkens Ave., Baltimore, MD 21229 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESPIRATORY Physician/ disease or condition Medical resulting in death) Examiner BILATERAL Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician at the burial-Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live Birth 2 ☐ Fetal Geath
4 ☐ Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Junknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 No ျ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1 Natural 5 Pendina 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined edical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title RE5-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE AVENUE ABHUL GOVIL M.D 4940 EASTERN

HMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32, Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Year 9018M Thomas Joseph O'Halloran, Jr. Medical 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Shady Grove Adventist HOSPita montgomery 8. Date of Birth (Month, Day, Yea March 14, If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Months Days Hours 1943 Washington, D.C. Min. 220-40-3227 67 Director のこてここ Usual Residence of Decedent or 28a-f shov notified at shov 10b. County 10a. State 10c. City, Town or Location Director 1 Tes 2 No Maryland Montgomery Darnestown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 14400 Seneca Road 20874 United States items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Black, White, etc. Thomas ò Completed by 1 Never Married 2X Married ☐ Yes 2 🛛 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Specify: 3 Divorced 4 Divorced White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " College (1-4 or 5+) Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygier Important: If item 27 is marked other than injury or other them. Self Employed Real Estate Appraiser Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Thomas Joseph O'Halloran, Sr. Patricia Ellen McDonald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon A. O'Halloran/Wife 14400 Seneca Road, Darnestown, Maryland 20874 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State November 23, Darnes Town Presbyterian Church Cemetery X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gaithersburg, Maryland 2010 Signature of Funeral Service Ligensee .22.Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc 300 West Montgomery Avenue, Rockville, Maryland 20850—2805 M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, Acute Myocardia disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any acting a limit of acuse. Enter Underlying Cause (Disease or linjury that initiated events Physician/Medical Examiner Due to for as a dominiquindin of the Hospital or Attending Physician: The law requires that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Cther (specify) in the past 12 months? Day Pregnant at time of death 2 No 9 Unknown Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an After this certificate 2 🗌 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital 2 1 No Certificate: To 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Accident work? iniury 5 Pending Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number D63112 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Coles Tara m. MD Medical 31. Date filed (Month, Day, Ye. NOV 2 3 2010

DHMH 17 Rev 7/2009

State

Registrar

NOV 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#18perFH, #23a, perPHYS, G909, 11/30/2010, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Рм Julie Carroll Och 2010 7:36 November Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4900 Jasmine Drive Rockville Montgomery Birthplace (State or Foreign Country) . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 6. Sex 7. Age (în yrs. last birthday, Hours 1 🗆 M 2 🗓 F Months Min. Yrs **Director** 217-42-3406 66 Texas December 5, Usual Residence of Deceden ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4900 Jasmine Drive 20853 <u>United States</u> 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Force Black, White, etc. \$ 1 Never Married 2 X Married ☐ Yes 2 🗓 No within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) 4 Elementary School Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Catharine Eleanor Carter permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. Don Llewellyn Carroll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank P. Och, Jr./Husband 4900 Jasmine Drive, Rockville, Maryland 20853 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) November 22, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Parklawn Memorial Park 2010 Rockville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home, Rockville, Inc. auan M01530 300 W. Montgomery Ave., Rockville, Maryland 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Olivopontocerebellar Atrophy Physician disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Examin Hospital or Attending Physician; The law requires that the death certificate be executed burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): anding physician are as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atter Ectopic pregnancy P in the past 12 months?
1 Yes 2 No Day Month Year 5 Other (specify) Pregnant at time of death signed by the ar 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ sate has been sig page 2 should b 1 ☐ Yes 2 IX No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 X No certificate 1 Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner?
1 Yes 2 X No Hospital Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) 유 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 XNatural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu М Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only one 29b. Signature and title of certi-29c. License number 29d. Date signed (Month, Day, Year) D35370 November 18, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jan Bachowski, 11125 Rockville Pike #104, Rockville, Maryland 20852 M.D. 31. Date filed (Month Day, Year) State 23 2010 Registrar

ORIGINAL

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0 ovemb Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death imore . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min. **Director** Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland thand Mental Hyglene.

27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at. 10a. State 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Yes 2 No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces? 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) (daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signat Funeral Service Licens 22. Name and Address of Facility 455 My 21216 23a. Part 1/Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician, SEVSIS Medical resulting in death) Due to (or as a consequence of): **Examiner** EMPUNITED BOWIEL Sequentially list conditions Examiner Dunità (or es e donsagnanca af) if any leading to immedicause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last the burial-tran attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy has been signed by the atte Month Year Day 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by mony 2 No 3 Probably 4 Unknown DISGNSU 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 within 24 hours after death.

To the Funeral Director; After this certificate To Be 25. Was case referred to medica filled in by the funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 Tes 2 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier mmm mmi

Registrar

31. Date filed (Month, Day, Year) strar's Signature 23 NUY

5601

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Michael Pacak 00 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Square dale ranklin HO 050 more Social Security Number Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □XM 2 □ F 75 Months Hours Min. JUME 16 1935 Pennsylvania Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location the Maryland 10d. Inside City Limits Director Md. Balto. Nottingham 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral hours after death with 8519 Heathrow Court Apt A 21236 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. ð 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X☐ No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n any injury or other traumatic event, the Medi ane. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11th Forklift Operator Western Electric Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Stephen Pacak <u>Helen Vansach</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8519 Heathrow Court Apt A Spouse Nottingham, Md,. <u>Helen Pacak</u> Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place;
Bayview 11-19-2010 Balto.Md. 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Road Nottingham. Md. 21236 23ar Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physiciani disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of). Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year ed by the a signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown peen s 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? Director: After this certificate 2 🗌 No 1 🗌 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 1 🗌 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending 1 Yes 2 No Investigation
6 Could not be Accident filled in by the 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d

To the Funeral Direct
completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifiei Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 17 2010 236663

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regi

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Jime of Death Physician/ Moon Medical Name (if not institution, give street and number) Town, or Location of Death **Examiner** 4c. County of Death SPINAL A 21 D 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In vrs. last birthday If Under 24 Hrs. 8. Date of Birth **Funeral** Hours Min Dec. 29 1 🔀 M 2 🗆 F 217-46-3626 **Director** 1947 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Baltimore Catonsville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 401 Shady Nook Avenue 21228 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ģ 1 ☐ Never Married 2 🔀 Married 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene.
7 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic 8 <u>Automobile</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be to Department of Health and Menta Important: If item 27 is marked any injury or other traumatic events. Joseph Papale Ruby Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene Papale Wife 401 Shady Nook Avenue; Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Meadowridge Mem.Park 11/20/2010 Elkridge, MD Donation 5 Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 Sign ture of Funeral Service License 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final TERSTITIA Physician/ disease or condition resulting in death) Medical to (or as a consequence of) Examiner 211) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury equentially list conditions Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filied in by the Innerial director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) 5 Other (specify) Month Day Year Pregnant at time of death g 🗌 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MOMA Division of Vital Records, 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an prior to con death? autopsy 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ Yes Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural iniury 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 124 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar

DOSEA

31. Date filed (Month, Day, Year)

RALTINORE, MD

21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

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Dhusis	0.7	I- For State Registrar 1. Decedent's Name (First, Middle,Last)	Certificate	e of Death		R 2. Date of Dea	eg. No.	3 5 7 5 5
Physici Medical Exam		James D.					Day Year r 14, 2010	0632 hrs
		4a. Facility Name (if not institution, give street a Johns Hopkins Hospital	nd number)	4b. City, Town, Baltimore	or Location of Death		4c. County of Death	1
Funeral Director		5. Social Security Number 6. Sex 218-88-6076	7. Age (In yrs. last birthda		ear If Under 24Hrs. Bys Hours Min.			untry)
Director		Usual Residence of Decedent	JF 46	Yrs.	, , , , , , , , , , , , , , , , , , , ,	7.10111	Bal	ltimore, MD
ow any		10a. State MD 10b. County Baltimore	10c. City, Town or I	ocation ingham				10d. Inside City Limits 1 Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number		10f. Zip Code		1	0g. Citizen of What Cou	
ith the last the last the last the last the last the last the last the last the last the last the last the last the last last last last last last last last		4228 Garland Aver		2.1 3. Was Decedent of F	236	ocifir Voc or No	U.S.A.	can Indian, Black,
death w	-uneral		ed Forces?		an, Mexican, Puerto F		White, etc.	
rs after tural", o	by F	3 Widowed 4 Divorced If Yes, Given Dates: 15. Decedent's Education (Specify only highes		1 Yes 2 N		ork done	Specify: Wh	ite
Baltimore, MD 21215-0036 7 3 4 7 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland bopartment of Health and Mental Hygiens. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner, must be notified at once.	Completed	Elementary/Secondary (0-12) Colle 1 2	ge (1-4 or 5+) duri	ng most of working lit Iechanic	fe. DO NOT use retire	ed)	Automob	ile
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MD 21; d 2 should b lth and Men n 27 is mar	To	19a. Informant's Name/Relationship (Type, Print Beverly Trimp/ M					mber, City or Town, State tingham, MI	
Baltimore, lemit Pages I and Department of Heal Important: If item injury or other tra		20a. Method of Disposition 1 Burial 2 Cremation 3 Remo 4 Donation 5 Other Specify:	val from State Evans	isposition (Name of conceptual place) Funeral - Bel Ai	111	Date 22 10	20c. Location - City or Forest Hil	
Balti permit. Departm Importa		21. Signature of Funeral Service Licen				napel 8	Cremation kville, MD	Services
Physician /Medical		23a. Part I Enter the disease, or complications the failure. List only one cause on each line.	hat caused the death. Do not en	nter the mode of dying	g, such as cardiac or	respiratory am	est, shock, or heart	Approximate Interval Between Onset and
Examiner		my mile and o dados (i mai diocado di	oin intoxicati as a consequence of):	on				Death
	Ŀ	Sequentially list conditions, if any, leading to immediate Due to (or	as a consequence of):					
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or	as a consequence of):					
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tox 68760, eath certificate be ex e attending physician for use as the burial	siciar	past 12 months?	ive birth regnant at time of death files files files files	Fetal death 3 Other (Specify)	Ectopic pregnan		Month D	Day Year
O. B. iat the de dd by the etached f	y Physic		ng to death but not resulting in	the underlying cause	given in Part I.	23e. Did to	obacco use contribute to	the cause of death?
cords, P.O. law requires that the has been signed by 2 should be detach	ted by	Cocaine use				1 Yes	an 24h Were au	ably 4 V Unknown topsy findings available
Division of Vital Records, P.O. Box 68760, vitin 24 hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours alter death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial.	Completed					autop	prior to comped?	ompletion of cause of
tal Recician: The l	Be	25. Was case referred to medical examiner? Hospital:			oe of Death (Check or Other, Nursing	nly one)		
n of Vit ding Physic Lafter this funeral dir	2	1 Yes 2 No 27. Manner of Death 28a.	Inpatient 2 ER/Outpa Date of Injury Month, Day, Year) 28b. Time		ury at Work? 2	8d. Describe	Residence 6 Other	:
ivision or Attendir after death. Director: A	cation	Natural 5 Pending Pading Property Prope	11/14/10 Fd 6	.00 аш —	res 2 No	nk	N	-
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 A Could not be determined (Spe	Place of Injury - At home, farm, cify) found: priva	ate dwelli	ng J	Baltimo	Street and Number of Rustate) 23 / Monti Ore, MD	ord Ave
D To the Hospital within 24 hours To the Funeral	Medical (29a. Certifier 1 Certifying Physician: To the (Check only pne) 2 Medical Examiner: On the base of the page of the	e best of my knowledge, death of asis of examination and/or inves					
To with con	Me	and mani 29b. Signature and title of certifier	ner stated.		se number	-	29d. Date signed (Mor	nth, Day, Year)
		30. Name and address of person who completed	cause of death /Item 22c)	0.0	.M.E.		November 15, 20	110
		Ling Li, MD Assistant Medical E		treet, Baltimore,	MD 21201			
St Regis	ate	31. Date filed (Month, Day, Year)	2. Registrar's Signature					

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TTEM#31perDVR, G909, 11/23/2010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🤈 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death PFARR UB 4 Physician/ 10:50 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 854 Shipfriend Road Middle River Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🕱 F Months 46 Hours Country) 214-46-0786 Director 1946 Dec. 14 MD Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Harford MD Aberdeen 1X Yes 2 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21076 131 Hanover Street USA items within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 10 Q. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2ॉ☐ No Specify. 3 XWidowed 4 ☐ Divorced Specify: White "natural" Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12 Grocery Store Cashier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anthony Joka Lillian L. Ostrowski other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Boyd/Daughter-in 854 Shipfriend Road, Middle River, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Final Journey Crem. 20a. Method of Disposition 20c. Location - City or Town, State Department of I 1 Burial 2 X Cremation 3 Removal from State ò 11/22/2010 Woodbine, MD injury 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21203 Signature of Funeral Service Licensee Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Monga disease or condition 4 Rass Medical resulting in death) e to (or as a consequence of Examiner Sequentially list conditions, Examine Due to ras a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events physician and s the burial-transit Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death?
1 Yes 2 No performe certificate 2 X No Yes or Attending Physician: 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Be SONIS RESTOENCE examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 2 📉 No 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1. Natural 5 Pending work? within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the only one) 29b. Signature and title of certifier 29c. License number 0066958 D.GERRY, MO 11/11/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2227 OLD EMMORTON RD 21015 ANIELLE strar's Signature 31. Date filed (Month, Day, Year) State NOV 23 2010 Registrar DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 4:20 PM November Physician/ PERKINS TRACY DIANE Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Regional Hospital Laurel Laurel 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **Funeral** 9/2/1980 Hours 1 □ M 2 🕱 F Clinton, MD **Director** 30 212-17-1606 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 XYes 2 No Maryland Prince George's Laurel 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral 20708 9643 Muirkirk Road # A162 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. 1 X Never Married 2 Married Yes 2X No δ Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: If Yes, Give Specify: Completed 3 Divorced 4 Divorced Black Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Full Time Student Everest College 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျ Troy Perkins Joan Proctor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joan Glenn / Mother 9643 Muirkirk Rd. # A162 Laurel, Maryland 20708 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 22. Name and Address of FacilityPope Funeral Homes, P.A. 4 ☐ Donation 5 ☐ Other (Specify) Resurrection 21. Signature of Funeral Service L 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part 1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Severe disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Esquentially list conditions if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1.☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnam a 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Ervthematosus -upus Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Encephalopath HNOXIC autopsy Aspiration Pneumonia performed? Yes 2 No 1 ☐ Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) Hospital: 1 Yes 2 No ၉ 1 Npatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No e Funeral Director: At bleted filled in by the fu Accident
Suicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. npleted (Check within 2 To the F only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month,

NOV 23

Day, Yea. 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

300

32. Registrar's Signature

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D69430

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November T9, 20T0 Τ. 6:15 A M Pinedo Rosa Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 8. Date of Birth 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🖾 F ^a1942 Peru 220-60-7014 68 Yrs September 4 Director Usual Residence of Decedent 28a-f shov at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 X No Maryland Montgomery Derwood 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 18111 Muncaster Road 20855 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. e filed within 72 hours after de tal Hygiene. da Aygiene. ed other than "natural", or it 2 1 Never Married 2 X Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 White 1 X Yes 2 No Specify: Peruvian Specify 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be file and Mental F ဂ္ Tantas Venancia Luis Nunez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau Mario R. Pinedo / Husband 18111 Muncaster Road Derwood. Marvland 20855 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗷 Burial 2 🗌 Cremation 3 🔲 Removal from State November 27, All Souls Cemetery 4 Donation 5 Other (Specify) 2010 Germantown, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850 21. Signature of Funeral Service Licens MO1607 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Upper gastrointestinal bleed disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 6 Months Metastatic Pancreatic Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Ducito for as a consequence of, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 🔀 No Day Pregnant at time of death Year signed by the a Id be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Bacteremia Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has page ; 1 Yes 2 No certificate 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital 1 ☐ Yes 2 X No Other: 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural injury 5 Pending within 24 hours after death.

To the Funeral Director: Al
completed filled in by the fu 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) City or Town, State) Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009 (Check

only one)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year) 2 3 2010

rangs treisinger

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

DO070427

29d. Date signed (Month, Day, Year)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Francis Freisinger, M.D. 1500 Forest Glen Road, Silver Spring, Maryland 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. (1) 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Ź0 2010 10:48AM M November Lawrence J. Pogue Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death 9914 Ridgeline Drive Village Montgomery ${ t Montgomery}$ If Under 1 Year Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) If Under 24 Hrs **Funeral** 6. Sex. 1 ☑ M 2 ☐ F 9. Birthplace (State or Foreign Days June 6, Months Hours Min Washington, D.C 1958 Director 17-78-7815 Usual Residence of Decedent 28a-f show 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2 X No Maryland Montgomery Montgomery Village the I 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? must be Funeral with 23a 9914 Ridgeline Drive 20886 United States items ? hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian "natural", or iter Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced Completed Year or Dates White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) within 72 and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) None None 12 Be Page 1 and 2 should be filed ment of Health and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 David O. Pogue Terry Joyner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 other tra David O. Pogue/ Father 8020 Cobble Creek Circle, Potomac, Maryland 20854 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 s
Department of H
Important: If ite
any injury or ot Montgomery Crematorium Inc. 1 Durial 2 X Cremation 3 Removal from State November 23, 2010 4 Donation 5 Other (Specify) Bethesda, Maryland 22. Name and Address of Facility Robert A Rockville, Inc. 300 Wes Rockville, Maryland 208 21. Signature of Fund Service Licenses Pumphrey Funeral Home/ Montgomery Avenue -2805 Α. M00335 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 4 Years Physician Lung Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) for use as the burial-transi Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) 9 Unknown the 9 Unknown sate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ី Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate ! 1 ☐ Yes 2 ☐ No Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this nin 24 hours after death.

The Funeral Director: After thi

The funeral illed in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1X Natural injury 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

To the within 2 To the comple

DHMH 17 Rev 7/2009

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cheryl A. Winchell, M.D. 19241 Montgomery Village Avenue, Montg

32. Registrar's Signature

29c. License number

D14555

Avenue, Montgomery Village, Maryland 20886

29d. Date signed (Month, Day, Year)

November 22, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 10e & 19b, per Fh G910 12/3/10 TT
State of Maryland Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9:55 Pence Josephine L. 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BURNUE AMNE ARUMDEL BATTMORE WASHINGTON MED CTR FLEN If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept. 4 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 1 M 2 X Director 213-16-0551 Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 🖪 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA 7061 Bay St. 21122 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11 Marital Status Black, White, etc. Armed Forces 1 Never Married 2 Married ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Specify: White 3X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೨ Salvatore Costa Modesta PENCE 1966 Tailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rose C. Bush (Daughter) 7061 Bay St., Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park Cemetery 11/20/10 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1 From the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nediate Cause (Final ACCIDENT CEREBROVASCULAR Physician Medical resulting in death) Due to (or as a consequence of): Examiner TEARS Sequentially list conditions, immediate cause. Enter Underlying Cause (Disease or iinjury Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ≥ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of page 2 s autopsy After this certificate has performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 No 26. Place of Death (Check only one) Be Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) Hospital: မ 1 Prinpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No Natural 5 Pending 2 ☐ Accident 3 ☐ Suicide Investigation 24 hours after deatle Funeral Director; 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined edical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certification 29d. Date signed (Month, Day, Year) 10059190 Nov. 16, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GEORGE BAFFOE-BONNIE GIEN BURNIE MO 301 HOSDITAL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 2 3 2010 Registrar

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	6.5		State Registrar Decedent's Name (First, Middle, Last)	1		Cei	lllica	le oi L	Jeani	2	Date of Dea	Reg. No		3. Time of Death
- 1980	Physici /Medic		Glethea Pu	rv15			1			No	Month van b	Day	16,2016	2:40P M
	Examin	er	4a. Facility Name (If not institution, give	street and number)	Hr	mp	4b. City	, lown, or	Location of Deat	n		¥0.	County of Dea	more
F	uneral	*	5. Social Security Number 6. Se		e (In yrs. i	last birthday)	If Unde Months		If Under 24 Hrs. Hours Min.	. 8.	Date of Birt (Month, Day	h v Year)		thplace (State or Foreign
D	irector		242-32-4424 Usual Residence of Decedent	M 2 A F	94	Yrs.	Wioritis	Days	Tiours Will.		4/13			ryland
ıryland	in result and welled hygelete. The standard other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		10a. State 10b. County		10c. Cify	, Town or Lo	ocation							10d. Inside City Limits 1 ☐ Yes 2 No
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after	or Iter	/Fu	1 ☑Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give	No		if Yes, sp 1 ☐ Yes	_	n, mexican, Puer Specify:	TO HICE	an, etc.)		Black, White	e, etc.
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star	f item (20a. Method of Disposition		20b. P	lace of Dispo emetery, cre	osition (Na	ame of other place	e)	Date			ocation - City or	
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30X	tendir or use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth	2 Feta	Ideath 3		pregnancy	,				23d. Date of de	elivery Day Year
.O. Box the death cert	the al	Physician/Medic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant at 9∐Unknown	t time of d	eath 5[Other (specify)						
I Records, P.O. Box 687 The law requires that the death certificate	been signed by the attending phys should be detached for use as the	y Ph	Part II. Other significant conditions co	ntributing to death b	ut not res	ulting in the u	underlying	cause giv	en in Part I.		23e. Did t	obacco	use contribute t	o the cause of death?
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ 03;06 John Napoleon Ranazzo 2010 Nov. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Medical Center Harford County Rel Air 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year 7. Age (In vrs. last birthday If Under 24 Hrs. 8. Date of Birth 5. Social Security Number **Funeral** (Month, Day, Year) Days Hours Min 1**X** M 2 □ F 21 Director 214-25-4316 Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10c. City, Town or Location 10a. State 10b. County with the Maryland Examiner must be notified at Director Belcamp 1 ☐ Yes 2 X No Harford County Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a or 21017 United States Funeral 4416 Greenwich Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married Yes 2 XNo permit. Page 1 and 2 should be filed within 72 hours after C Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin Completed by If Yes, Give Year or Dates. 1 ☐ Yes 2XXNo Specify: Specify: White 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) D&L Window Tinter 10 N/A Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Brenda Lee Mann Thomas Louis Ranazzo, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3639 Burkins Road, Street, Maryland 21154 Mr. Thomas Ranazzo (Father) 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral Chapel 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 11/21/2010 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services-BelAir 3 Newport Drive, Forest Hill, Maryland 21050 21. Signature of Funeral Service Licensee 103 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between nse, and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a colu and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy Month Year in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 1 Yes 2 9 Unknown 4 ☐ Pregnant a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 X Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 \square No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Hangina 11/11/2010 1515 PM Accident Investigation 3 X Suicide 4 ☐ Homicide 6 Could not be Place o Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Strott and Imper or Rural Route Number, City or Town, State) determined Home Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie WV30. Name and address of person who completed cause of death (Item 23a) (Type, Print) er Chisapeake Dr. Be State Registrar

ORIGINAL

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MILDRED Physician/ Month (2010 OBBINS 11:55 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Tate Hospice House Linthicum If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗷 F New Jersey Months Days Hours Min JULV12, 1917 93 168-16-2797 Director Usual Residence of Decedent 28a-f shov I Hygiene. I other than "natural", or items 23a or 28a-f showent, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits West River Anne Arundel Maryland 1 Yes 2x No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 20778 159 Owensville Road permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muone. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status rmed Force Black, White, etc þ 1 Never Married 2 Married 2 X No 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify. Specify: White Completed 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working ioner life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Christian Science Pract-Self-Employed Be 18. Mother's Name (First, Middle, Maiden Surname) Frances Augusta Weisel 17. Father's Name (First, Middle, Last) 2 Louis Tobias Klauder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 159 Owensville Road,WestRiver,Maryland20778 Susan R. Wetherill/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial X Cremation 3 Removal from State Ardent" Cremation, The 11-22-10 Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21214 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MarzulloFuneralChapel,6009HarfordRoad,Baltimore,MD. mulail 23a. Part 1. Enter the disease, or plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or in that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 4 Pregnant : 9 Unknown Month Pregnant at time of death 1 Yes 2 No P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 🗌 No 1 Tyes Yes 25. Was case referred to medical a 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 🗆 No ☐ Accident ☐ Suicide Investigation Director: / Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

Registrar

State

441

ame and address of person who completed cause of death (Item 23a) (Type, Print)

-Ca 1

31. Date filed (Month, Day, Year,

MUDA

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death I8, Physician/ RUTHERFORD 2010 DAVTD JAMES November 12:54pM Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death 3563 Ft. Meade Road Laurel Anne Arundel . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month Day You 6. Sex 7. Age (In vrs. last hirthday) 9. Birthplace (State or Foreign Funeral 1XX M 2 □ F Days Hours Year) 1943 157-32-3427 67 New Jersey Director Usual Residence of Decedent 10h County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and: If if item 27 is marked other than "natural", or items 23a or 28a-f show the traumatic event, the Merical Examiner must be notified at ury or other traumatic event, the Merical Examiner must be notified at 10a State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Laurel 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3563 Ft. Meade Rd., Apt. 626 20724 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ò 1 Never Married 2 Married 1 ☐ Yes 2XX No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Yo Specify: Specify: White 3 Widowed 4 X Nivorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12)
Grade 12 Public Service College (1-4 or 5+) Customer Service Electric & Gas 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Ralph Rutherford Clara Schafer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Justine A. Lehner daughter 9494 Vollmerhausen Road Columbia, Maryland 21046 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important; If ite
any injury or otl 20c. Location - City or Town, State 1 Burial 2 XXremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) W. Arundel Crematory: 11/22/2010 Odenton, Maryland 21. Signature of Funeral Service Licensee ²²Donaldson Funeral Home, P.A. M00770 313 Talbott Avenue Laurel, Maryland 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Cardiac Arrest disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Dilated Cardiomyopathy 10 years Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami Hypertensive Cardiovascular Disease 10 years the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical History of Alcohol Abuse 15 years Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Pregnant at time of death Day Year 2 No Unknown 9 Unknown היושו uns certificate has been signed by i funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4XXUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 A 2XXN0 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 ☐ Yes 2 ☐XNo ၉ 4 Nursing Home 5 Kesidence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 XXatural 5 Pending work after death. 2 🗌 No 1 Tes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify)

24 hours a within 2

State

Registrar

Medical

29a. Certifie

(Check

only one 29b. Signature and title

Bachubhai

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Manejwala, M.D.

1 👺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

November 19, 2010

20707

29c. License number

D13671

14201 Laurel Park Drive Laurel, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 17, 2010 11:30 A M Riefner Mary K. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Baltimore 3514 Ailsa Road 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F Months Month 27-1930 Hours 80 **Director** 217-24-6101 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director N/A Baltimore Maryland 1 Yes 2 No 10f. Zip Code 0 109. Citizen of What Country? the Medical Examiner must be Funeral 23a 3514 Ailsa Road 21214 within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 5 1 Never Married 2 X Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 'natural", 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business Industry alth and Mental Hygiene. 27 is marked other than "r r traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna Kitson Thomas J. Riefner permit. Page 1 and 2 should be Department of Health and Ment Important; If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2503 Fairview Drive Mrs. Susan Kehr - Daughter Forest Hill, MD 21050 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Gardens of Faith Cem! 11-20-2010 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signatury of Juneral Service Lin 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ jastno disease or condition mon Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Examine Due to (or as a consequence of) and I-transit death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Other (specify) detached 1 ☐ Yes 2 ☐ Unknown 9 Unknown s been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed prior to completion of cause of death? page e Hospital or Attending Physician: The I 24 hours after death.
9 Funeral Director: After this certificate h leted filled in by the funeral director, page 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital Other: 1 Yes 2 ANO မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) residence Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certi 29c. License number 29d. Date signed (Month, Day, Year) NOU 2010 Loch Raven Blud, Baltimole, ND 21239 30. Name and address of person who co pleted cause of death (Item 23a) (Type, Print) Padaett 5601 uarles 31. Date filed (Month, Day, Year, State

DHMH 17 Rev 7/2009

Registrar

23 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			Decedent's Name	(First, Middle	e, Last)							2. Date of De	ath		3. Time	of Death
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HMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#5perFH, G909, 11/2372010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Vov Carbo 8:65 A Physician/ las wan Medical 4c. County of Death

Bulli more **Examiner** alls town If Under 24 Hrs. If Under 1 Year 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** (Month, Day, India Yrs 70 Director Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Examiner must be notified at **Funeral Director** 1 🗌 Yes 2 💢 No 28a-f Owings Mills MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 0 items 23a USA 10119 Lyons Mill Road 21117 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 XNo Black, White, etc. 1 Never Married 2 X Married and Mental Hygiene. Completed by 1 ☐ res If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Asian Indian 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical sones. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Warehouse ٨, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Balwant Kaur Daulat singh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10119 Lyons Mill Road Owings Mills, MD 21117 Harsimran Singh, son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Metro Crematory, Inc. 11/28/10 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death indiovascular Disease Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed g physician and as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death 9 Unknown P.O. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 10 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) filled in by the funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 K No |은 1 Yes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: All completed filled in by the fu Investigation Accident 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certif D0052950 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21133 Randallstown, MD 5401 Old Court Road LaMont C. Smith, M.D.

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Karleene Ellen Shealey 5:42 A.M 2010 November Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford County Upper Chesapeake Medical Center Bel Air Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 - M 2 X Days Hours 027-30-6699 69 Springfield, MA Director 1941 Jan. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Harford County Forest Hill 1 Yes 2 XNo 10e. Street and Number 10g. Citizen of What Country? 1914 Munsey Drive 21050 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 22 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Bace - American Indian. Black, White, etc. 1 Never Married 2 X Married Completed by 1 ☐ Yes 2 X No Specify: Specify: White "natural". 3 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry //2//C Baltimore/Maryland 21215-(Specify only highest grade completed) Maryland Association permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important; If item 27 is marked other than "any injury or other traumatic event, the Menone." Elementary/Seconday (0-12) College (1-4 or 5+) of Appraisers Asministrative Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond A. Gregoire Katherine M. Supple 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Harry M. Shealey (Husband) 1914 Munsey Drive, Forest Hill, Maryland 21050 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Nov. 24,2010 Forest Hill, Maryland Evans Funeral Chapel 21. Signature of Funeral Service License 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services—BelAir e Newport Drive, Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onser and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a con Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of Cause (Disease or iinjury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of) physician Physician/Medical Division-of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown page 2 should be detached for Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autop performed: 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical B B 26. Place of Death (Check only one) examiner? Hospital 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury 2 Accident
3 Spin 5 Pending s after death. 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Natice Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one Signature and title of certifie H3902 2010 person who completed cause of death (Item 23a) (Type, Print) 08 853 32. Registrar's Signature NOV 23 2010 Registrar

Shealey, Karleene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 19, 2010 Physician/ James M. Strickland Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Parkville 2418 Bradford Road Social Security Numbe Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Sex 1 X M 2 □ F **Funeral** (Month, Day, Year) une 14,1924 North Carolina 238-26-0052 Months Davs Hours 86 Director June Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland **Funeral Director** MD Baltimore Parkville 1 Yes 2 XNo 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 21234 2418 Bradford Road U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces? 1X Yes 2 \(\sum_{No} \) WWII Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White If Yes, Give Year or Dates Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) 1 2 Self Employed Construction Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James C. Strickland Kate M. Mullinix Page 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print)

Jane Strickland/ Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2418 Bradford Road, Parkville, MD 21234 of Health 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Evans randor v or other place) Chapel—Bel Air November permit. Page 1 Department of Important; If it any injury or o 1 Burial 2 X Cremation 3 Removal from State 22, Forest Hill, MD 2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Evans Funeral 8800 Harford Signature of Funeral Service Ligenses Chapel & Cremation Road, Parkville, MD 23a. art 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho k, or heart failure. List only one cause on each line. Immedi le Cause (Final dise se/ r condition resulting in death) Onset and Death Physician Medical Due to (or as a consequence of Examiner Securentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): attending physician and for use as the burial-transit The law equires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year ed by the a 9 Unknown t een signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? lated Cardiomy upathr Invonic Renalinsuffic ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Completed Chronic Ren 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificat has pege 2 s 1 Yes 2 No Yes 2X No or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital (2 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury 1 💢 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital edical 29a. Certifier 🛚 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DHMH 17 Rev 7/2009

State Registrar only one)

havles M.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed gause of death (Item 23a) (Type, Print)

rrisonML

Registrar's Signatur

29b. Signature and

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

29d. Date signed (Month, Day, Year)

Marshalle Dr. Elknows MD21

10-08908

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Canton Seliman		S1 1- For State Registrar	ate or Ma		iπment of H tificate of D	eaith and Menta eath		eg. No.	010	36776
Physicia Medical Examir	an/	1. Decedent's Name (First, Midd	le,Last)	Co	ellman		2. Date of Dea		Year	3. Time of Death 1755 hrs
		4a. Facility Name (if not institute	on, give street er			City, Town, or Location of D			nty of Death	
		St. Agnes Hospital		15 75 85 55		altimore	and le bis de	NA	nedo si	
Funeral Director	4	5. Social Security Number 216-33-6272 Usual Residence of Decedent	6. Sex	7. Age (In yrs. la	^ · ·	Under 1 Year If Under 2 Months Days Hours	Min. July	3, 199,		thplace (State or Foreign untry)
w any		10a. State 10b. County			Town or Location		····			10d. Inside City Limits 1 Yes 2 No
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	Elementary/Secondary (0-12)		ge (1-4 or 5+)		of working life. DO NOT use		School	0/	,
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Baltimore, permit. Pages I an Department of Hea Important: If iter injury or other tra		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other S	_	val from State	lace of Disposition rematory or other p	(Name of cemetery, place)	Date / 127/10	Lars	on - City or 1 AOW NO	Town, State
Balti permit. Departri Imports	Ì	21. Signature of Funeral Service			22 Name	end Address of Facility	ynerabl	tone	PAJO	229
Physician /Medical		23a Part I. Enter the disease, or railure. List only one cause	on each line.			ode of dying, such as cardi	iac or respiratory arr	est, shock, or	heart	Approximate Interval 8etween Onset and Death
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Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the Paper of the Paper of the Paper of the Paper of the Paper of the Hospital or After this certificate has been signed by the attending physician and inpletely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/I	past 12 months? 1 Yes 2 No 9 Unit	4 P	regnant at time of dea	H	(Specify)				
s, P.O. Bo	<u>ā</u>	Part II. Other significant condit	ons contributi	ng to death but not re	sulting in the unde	lying cause given in Part I.		obacco use co 2 ✓ No		he cause of death? ably 4 Unknown
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Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical	one) 2 Medical Exa	miner: On the ba and mann	asis of examination an		at the time, date and place, in my opinion, death occum				
	Σ	29b Signature and title of certifie		200 i	4-0	29c. License number O.C.M.E.			igned <i>(Mont</i> er 21, 20	th, Day,Year) 10
)		30. Name and address of person Patricia Aronica-Pollal	11.	cause of death (Item 2	,	1 Penn Street, Baltin	nore, MD 2120	1		
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- interest	Examir	ner	4a. Facility Name (if not institution, give: Mercy Medical	Center		4b. City, Town, o Baltime	r Location of Deat	h	1	County of Death	_	=
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	and show	៦	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Loc	ation		•			10d. Inside City	Limits
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	e filed within 72 hours after death with the Maryland tal Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral D	10e. Street and Number	11 Ave. A	か B-2	10f. Zip Code 213	206		10g. Citiz	zen of What Cou USA	ntry?	
	r death or items uiner m		11. Marital Status 1 ☑ Never Married 2 ☐ Married	12. Was Decedent Ever in U. Armed Forces?	3. 13. W	las Decedent of H Yes, specify Cuba	lispanic Origin? (Si an, Mexican, Puert	pecify Yes or No- to Rican, etc.)	1	14. Race - Ameri Black, White,		
9036	urs afte ural", c	ted by	3 Widowed 4 Divorced	1 ☐ Yes 2 🗖 No If Yes, Give Year or Dates.	1	☐ Yes 2)X Â No	Specify:		5	Specify:Bla	ick	
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Maryland 21215-0036	should be filed and Mental Hy, is marked oth raumatic event	To B	17. Father's Name (First, Middle, Last)	Scott			18. Mother's Nai	me (First, Middle,	Maiden S LNC	A /		
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altimore,	ge 1 and 2 It of Healt If item 2 or other		20a. Method of Disposition 1 Burial 2 Cremation 3		Place of Dispos	ition (Name of atory or other place	ce) 12/1	/2010	20c. Loc	cation - City or T	own, State	
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P.O.	that the ned by detacl		Part II. Other significant conditions co	ntributing to death but not res	ulting in the un	derlying cause giv	ven in Part I.	23e. Did t	obacco us	e contribute to t	he cause of dea	ath?
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Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, stree	et, factory, office		28f. Location (S City or Tov		Number or Rura	l Route Number	ŗ
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)	Vithi Von th		29b. Signature and title of certifier			29c. License				signed (Month,		
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			Nikita Shah, MD	301 St. Paul	Place,		e, MD 2	1202				
	Sta Registra		31. Date filed (Month, Day, Year)	32. Figistra e Signat	ture	and I						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death VOVEMBER 04:50 A M Storms James 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death TOWSON BALTIMORE SAINT JOSEPH MEDICAL CENTER 8. Date of Birth (Month, Day Sept 14 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 9. Birthplace (State or Foreign Days 1 🛛 M 2 🗆 F Months Hours Maryland 1928 217-24-3267 82 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 X No Maryland Baltimore Timonium 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? 21093 Brooking Court, #201 USA 12. Was Decedent Ever in U.S. Armed Forces?
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Lemmon Funeral Home of Dulaney Valley Inc.
10 W. Padonia Road. Timonium. Marvland 21093 23a. Part 1. Inter t e disease, or complicitions that ca shock, or hear failure. List only one ause on eac sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (inal disease or condition resulting death Onset and Death HYPOXEMIC RESPIRATORY FAILURE Due to (or as a consequence of) DISTRESS SYNDROME ADULT RESPIRATORY PNEUMONIA Due to (or as a consequence of): SEPTIC SHOCK 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician/ Medical Examiner Examiner

signed by the attending physician and d be detached for use as the burial-transi

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Director: After this certificate

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Certificate:

Medical

29a. Certifier

To the Hospital or Attending Physician: The law requires that the death certificate be

Division of Vital Records, P.O. Box 68760

Physician/

Medical

Examiner

Funeral

Director

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or than "natural", or items 23a or the Medical Examiner must be

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Director

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events resulting in death) Last

Physician/Medical IF FEMALE:

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 No

25. Was case referred examiner?	<i>b</i>
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide	5 Pendir Investi 6 Could determ

5 Pending Investigation 6 Could not be

determined

Hospital 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year)

Other: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No

4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

TOWSON

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death	occurred at the time, date and place, and due to	the cause(s) and manner as stated.
Bb. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day,
1 led selfaction	400 52015	11-10-7

HOO 52065

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

26. Place of Death (Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RONALD D. JEFFREYS D.0. 7601 OSLER DRIVE

State Registrar

32. Registrar's Signature 31. Date filed (Month, Day, Year)

8 21

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month John Campbell St. 2010 Рм November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince George's Prince George's Hospital Center <u>Cheverly</u> ial Security Number Date of bill. (Month, Day, Yea Birthplace (State or Foreign Country) If Under 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 📉 M 2 🗆 F Days Hours Director Yrs. 64 053**–**38–7338 January 1946 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 28a-f 1 Yes 2 X No Maryland Montgomery Potomac 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 10910 Old Coach Road 20854 <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 0 þ 1 Never Married 2 X Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify: "natural", Specify: White Completed 3 Divorced Year or Dates any injury or other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Capture Manager Management Services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental ! Important: If item 27 is marked o ဂ္ John Wilson Anne Camphell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia St. Clair 10910 Old Coach Road, Potomac, Maryland 20854 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Montgomery Crematorium, Inc. 1 Burial 2 X Cremation 3 Removal from State November rium, Inc. 2010 Bethesda, Maryland

22. Name and Address of Facility
Robert A. Pumphrey Funeral Home, Chevy Chase, In 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Clense Inc ouan M01530 7557 Wisconsin Avenue, Bethesda, Marvland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions if a y, healing to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examin Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transi resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page perform 2 X No 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 ី No ည 1 Yes 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Funeral Directory completed filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar 3001 Hospital Drive, Cheverly, Maryland

20785

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Catevenis, M.D.

James

Date filed (Month, Day, Year,

			for State	State of Ma	•	epartment of Certificate of		and Mental Hy		^	06771
			Registrar 1. Decedent's Name (First, Middle,	Last)		Certificate of	Dealii	2. Date of De	Reg. No.		3. Time of Death
ı	Physic		Kenne th	R Silver	1.12			Month		Year ID	150 A M
N'A	/Medi Examiı		4a. Facility Name (If not institution,			4b. City, Town,	or Location of	f Death	4c. County o		,
E	ž.	4	Sohns Hopkins	Bay view Co	C Conte	2 Balt	noc F	10	Baltu	nee	ati
	Funeral				(In yrs. last birt	Months Days		Min. 8. Date of Bit (Month, Date	rth ay, Year)	9. Birthp	place (State or Foreign
'n.	Director 		215-34-8769 Usual Residence of Decedent	1LfM 2Ll F 73	3	rs. Months Bays		4/14	11937	Mar	yland
	yland now		10a. State 10b. County		10c. City, Town	or Location				1	0d. Inside City Limits
	Mar a-fst	ig	MD Balti	more			Dunda:	1k			1 □ Yes 2XQXNo
	th the)ire	10e. Street and Number		···	10f. Zip Code			10g. Citizen of Wh	nat Cour	itry?
	ath wi	ra	8173 Gray Have	n Road			21222		United	Sta	ates
	er de	Funeral Director	11. Marital Status	12. Was Decedent Ev Armed Forces?		13. Was Decedent of If Yes, specify Cu	Hispanic Orig ban, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)	14. Race Black	- Americ	an Indian,
36	rs aft	by F	1 ☐ Never Married 2 🛣 Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 ∏Yes 2★□ No If Yes, Give Year or Dates:)	1 □ Yes 2 🗷 No	Specify:		Specify:	1.71	nite
21215-0036	within 72 hours after death with the Maryland lene. than "natural", or items 23a or 28a-f show in Medical Evaruine: must be notified at	ted	15. Decedent's	Education	16a.	l Decedent's Usual Occi	upation		16b. Kind of Bus		
218	within 7 ene. than "n	ple	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5+		(Give kind of work done life. DO NOT use retire	ed) during most (of working			,
21		Completed	G.E.D.		<u></u>	Millwrig	ht		Stee1	Indu	ıstry
Maryland	e d the	Be	17. Father's Name (First, Middle, La William	schultz			18. Mother	's Name (First, Middle	,)	
ryg	should be and Menta s marked umatic ev	은						Mamie Saue			
Ma	and 2 sho lealth and m 27 is ma		19a. Informant's Name/Relationshi	, , ,	1	Mailing Address (Stree					
ē,	s 1 and f Health item 27 other ti		Mrs. Joan M. Sc 20a. Method of Disposition		20b. Place of	173 Gray H. Disposition (Name of crematory or other plants)	aven Ro	Dad Dunda	Lk, Maryl 20c. Location - C		
Baltimore,	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any injury or other traumatic once.		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	Removal from State		, crematory or other pla s of Faith		11/19/2010		•	Maryland
alti	permit. Departm Importa any inju		21. Signature // neral Servi	ns e	111			al Home of			-
<u>m</u>	8 3 E 6 8	1 10	y proller	Jusu !	//	7922 Wise	Ave.	Dundalk, N	Dundark, 121222		•
ı			23a. Part 1. Enter the disease, or conshock, or heart failure. List or	omplications that caused to	ne death. Do no	ot enter the mode of dy	ing, such as c	ardiac or respiratory a	rrest,		Approximate Interval Between
4	Physician	ŕ	Immediate Cause (Final disease or condition	Termina	0 1	m					Onset and Death
J	/Medical Examiner		resulting in death)		consequence of		4. 1		1		
		-	Sequentially list conditions,	b. Due to (or a a		ssive daner				>	year
	uted J insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or a yar	consequence of	" (CONTICO	basal	degene le	(Tron)		
Ć,	exec in and ial-tra	Еха	resulting in death) Last	c Due to (or as a	consequence of):		-		-	
68760,	eath certificate be executed attending physician and for use as the burial-transit	edical		d							
89	ertifica ing ph e as th	Med	IF FEMALE:								
30	The law requires that the death cer ate has been signed by the attendir bage 2 should be detached for use	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2		3 ☐ Ectopic pregnan	cy		23d. Date		•
P.O. Box	the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at ti 9 ☐ Unknown	me of death	5 Other (specify)			Mont	n	Day Year
σ,	that the de ned by the detached t		Part II. Other significant conditions	s contributing to death but	not resulting in t	he underlying cause oi	ven in Part I	23e Did to	obacco use contrib	oute to th	e cause of death?
Records,	uires tha signed Id be det	d by				,		1 🗆)			abiy 4 ☐ Unknown
O C C	w requir s been si should	lete						24a. Was	an 24h W/o	are auter	osy findings available
Re	sician: The law certificate has b irector, page 2 s	Completed						autop	psy pri rmed? de	or to con ath?	npletion of cause of
Vita	ian: '	BeC	25. Was case referred to medical				26. Place o	1 ☐ Yes of Death (Check only o		Yes	2 400
>	Physic this ce	일	examiner? 1 Yes 2 No	Hospital: 1 Inpatient	2 🗌 ER/Outp	atient 3 DOA Otl		sing Home 5 Resid		(Specify	·)
ם ם	ding Ph h. After th funeral	on:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day,)	(ear) 28b. Tii	ne of 28c. Inju			now injury occurred		/
Sic	ttend death ttor: /	cati	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not	he		7.1]Yes 2□No				
Division of	I or Atten after death Director: I in by the	Certification:	4 Homicide determine	d 28e. Place of Injury building, etc.	· - At home, farn (Specify)	n, street, factory, office		28f. Location (S City or Tow	Street and Number vn, State)	or Rural	Route Number,
_	pita ours eral filled		29a. Certifier 1 Certifying	Physician: To the best of	mv knowledge.	death occurred at the t	ime date and	nlace, and due to the	Causo(s) and man	nor no of	atad
	To the Hos within 24 hor To the Fun completely	Medical	(Check only 2☐ Medical Ex	aminer: On the basis of eand manner state	xamınatıon and,	or investigation, in my	opinion, death	occurred at the time,	date and place, an	d due to	the cause(s)
	To the within 2 To the I complet	ž	29b. Signature and title of certifier	\		29c. Licens	se number		29d. Date signed (Month, [Day, Year)
			hish Bol	IT MD		1)5-	1768		11/16/10	>	
	10		30. Name and address of person wh	o completed cause of dea	th (Item 23a) (T	/pe Print)	0:	71.1	MO	0,0	27(/
			31. Date filed (Month, Day, Year)	32 Raniabric	WY WS	my view	Civille	c, Daltmo	ne Ily)	212	67
	Stat Registra		NOV 2 3 2010	Que 32. Registar's	17	No.					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 20 20°90 7:30 Steven Smeton Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Baltimore 4b. City. Town, or Location of Death **Examiner** Towson Gilchrist 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🎛 M 2 🗆 F Months Days Hours JU194, 916 Yell 925 85 Mary Tand 220-14-8525 **Director** Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f Maryland Baltimore Towson 1 Yes 2 XNo 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? items 23a or ner must be n Funeral 21204 U.S.A. 47 Theo Lane permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Evaminar m... 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. by 1 Never Married 2 K Married Maryland 21215-0036 White 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired Elementary/Seaonday (0-12) College (1-4 or 5+) Civil Engineering Landscape Architect Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Catherine Krug Stephen Smeton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
47 Theo Lane Towson, Maryland 21204 19a. Informant's Name/Relationship (Type, Print) CarolynSmeton /Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
[Hilltop Service Corp. 1 ☐ Burial 2 👿 Cremation 3 ☐ Removal from State 11-22-2010 Towson, Maryland 4 Donation 5 Other (Specify) ^{22. Name and Address of Facility} Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 21. Signature of Fune 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Priysiciani Reumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner spliano Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last ceremovusular stroke attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires Emply Sema, normal pressive Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy autope, performed? this certificate 2 No 1 🗌 Yes Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of s after death. 28c. Injury at 28d. Describe how injury occurred 5 Pending work' 1 Yes 2 No Investigation Accident filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

State Registrar

DHMH 17 Rev 7/2009

within 24 hours To the Funeral I

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifie

laiva 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

701

32. Registrar's Signature

Pat-el

N charles St

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

DOD 70635

Suite 4105

11/20110

Bultmore MD 21204.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				For	State of Ma	aryland	/ Depa	artment of I	Health and	Mental H	ygier	ne		
				State Registrar			Cer	tificate of l	Death		Reg. I	No. 20	10	36776
		Physicia Medi		1. Decedent's Name (First, Middle, I	Rita Sı	mith				2. Date of D Noveml		21, 20	OTO	3. Time of Death 12:28 aM
		Exami	ner	4a. Facility Name (if not institution, g Stella Maris	ive street and number)				r Location of Deat	h	- (4c. County o	f Death	
		Funeral	г		. Sex 7. Age	(In yrs. last	birthday)	_If Under 1 Year	If Under 24 Hrs		irth			ace (State or Foreign
		Director	l	019-14-7715	1 D M 2 X F	88	Yrs.	Months Days	Hours Min.		^{ay} 192	2	Cana	da_
		show at	5	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	ation					10	d. Inside City Limits
		Maryla 18a-f tified	Director	MD Balt	imore		Towso	n						1 Yes 2 No
		with the I s 23a or 2 ust be no	Funeral Di	10e. Street and Number 7606 Far Hills	Drive			10f. Zip Code 2128	36		10g. (Citizen of Wh		
	Maryland 21215-0036	permit, Page 1 and 2 should be filed within 72 hours after death with the Mayland Department of Health and Mental Hygiene. Important: If teem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 Xo If Yes, Give Year or Dates.		If	Vas Decedent of Ho Yes, specify Cuba	an, Mexican, Puert	pecify Yes or No o Rican, etc.)	-	14. Race - Black, Specify:	- America White, et	c.
į	<u>,</u>	72 hou "natu edica	plet	15. Decedent's (Specify only highest			16a. Deced	ent's Usual Occup ind of work done o	ation	rkina	16b.	Kind of Busi	iness Indu	stry
3	7	rithin 7 ene. r than	Completed	Elementary/Seconday (0-12)	College (1-4 or 5+	·)	life. DC	NOT use retired) Homemaker		707.19		Own	home	1
7	ָס ס	iled will Hygi other	Be	17. Father's Name (First, Middle, Las	t)				18. Mother's Nar	me (First, Middle	Maide			
	ylar	id be f Menta arked atic ev	은	John Franc	is McBr	ide			Mary		, 1111111111111111111111111111111111111	McQu	uaid	
	, Mar	nd 2 shou lealth and m 27 is m		19a. Informant's Name/Relationship Stephen I. Smit			19b. Mailin 7606	G Address (Street a	and Number or Ru S Drive,	ral Route Numb Towson	er, City o	or Town, Stat		de)
: 75	baltimore,	nt of H		20a. Method of Disposition 1	☐ Removal from State	cem	etery, crem	ition (Name of atory or other plac	· ·	Date		Location - C	-	
12		artme artme ortani injury		4 ☐ Donation 5 🗶 Other (Spe 21. Signature of Funeral Service Lice	_			Valley		24/10	Ti	monium	n, M	1D
ò	กั	Imp Per Imp any any	d	In	WIIIIam (u 22.	Name and Addres	Rd., To	ok Towso	ab F	212641	Hom	e, Inc.
		h sisism/		23a. Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final	mplications that caused to one cause the each line.	he death. D	Do not enter	the mode of dying	g, such as cardiac	or respiratory a	rrest,		- tr	Approximate Interval Between
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>	th Cer	attending p	Completed by Physician/M	23b. Was decedent pregnant	23c. If yes, outcome of 1 Live Birth 2	☐ Fetal de	eath 3 🗌	Ectopic pregnancy	y		1	23d. Date of	*	
BEF	ie de	the a	ysic	in the past 12 months? 1 ☐ Yes 2 ☒No 9 ☐ Unknown	4 ☐ Pregnant at ti 9 ☐ Unknown	ime of deat	th 5 ∐	Other (specify)				Month	Da	ay Year
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SMITH NO	aw re	as be	nple							24a. Was		24b. Wer	e autopsy	findings available
TH	The	certificate has rector, page 2								perfo	ormed?	dea		
SMITH Vital R	sician	certifi	m	25. Was case referred to medical examiner? 1 ☐ Yes 2 ⚠ No	Hospital:			Othor	ce of Death (Chec					
	Phy B	er this	e: To	27. Manner of Death	1 ☐ Inpatient 28a. Date of injury	288	o. Time of	3 ∐ DOA 28c. Injury	4 KJ Nursing He	ome 5 Resident 28d. Describe f			Specify)	
ARE	endin	or: Aft.	fical	1 Natural 5 Pending 2 Accident Investigation		(ear)	injury	work?	/es 2 □ No	2 3 3 3 3 3 3	ion injui	y occurred		
MARGARET Division of	tal or Att		l Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined		- At home, Specify)	farm, stree	t, factory, office		28f. Location (S City or Tow	Street an	nd Number of	r Rural Ro	ute Number,
7	Hospit	within 24 hours To the Funeral completed fillec	Medical	29a. Certifier 1 Certifying Ph (Check 2 Medical Exar	ysician: To the best of my niner: On the basis of exar	/ knowledg	e, death oc	cured at the time,	date and place, an	nd due to the ca	use(s) a	nd manner a	s stated.	(a) and
	o the	ithin 2 o the		only one) 3 Certifying Nu	rse Practioner: To the be	st of my kno	owledge, de	ath occurred at the	time, date and plac	ce, and due to the	e cause(s) and manne	er as stated	d.
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10			-	30. Name and address of person who	completed cause of deat	h (Item 23a	(Type, Prin	nt)	, _ / T		140	· CHIDE	1 L	- , ago
W				ERNESTINE WRIGH	T, M.D. 23	00 DU	LANEY	VALLEY 1	ROAD TI	MONIUM,	MD	21093		
		State Registra		NOV 2 3 2010	32. Registrar's	Signature	2							
KX DI	НМН	17 Rev 7/200		MUY & J LUIU	enema pp.	7							-	

NOVEMBER 21, 2010

MARGARET SMITH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#29d PerPHYS#30 PerDVR, G909 11723/2010, WS
State of Maryland Bepartment of Health and Mental Hyglene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^{Day} 19 NOVEMBER ' MYRON ELLIOT SHANE 2010 Medical 9:18 AM Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3601 CLARKS LANE, #907 BALTIMORE N/A Social Security Number Birthplace (State or Foreign Country)
 MT) **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Days 1 X M 2 D F Months Hours Director 551-03-5054 1^{(M}07th, 87, 1^Y918 92 Yrs MD Usual Residence of Decedent show 10a. State 10b. County should be filed within 72 hours after death with the Maryland Ħ 10c. City, Town or Location Director 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f s other traumatic event, the Medical Examiner must be notified MD N/A 1 Yes 2 ☐ No BALTIMORE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3601 CLARKS LANE, #907 21215 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian þ 1 Never Married 2 Married Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: 3 ☐ Widowed 4 💢 Divorced Completed Specify. WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) 5+ Elementary/Seconday (0-12) ANESTHESIOLOGIST MEDICINE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 MORRIS SHANE IDA FRIEDMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .. Page 1 and 2 sh tment of Health a tant: If item 27 is FRANK SHANE/SON 3104 OLD POST ROAD, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ARLINGTON CHIZUK AMUNO 11/21/2010 BALTIMORE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Cut 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode ordying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on earnyline: Approximate Interval Retween Immediate Cause (Final Physician/ Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Month Day been signed by the s should be detached g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed certificate Yes 2 No 1 Yes 2 No 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 2 No ဂ္ Other: this (1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c, Injury at work? 1 ☐ Yes 2 ☐ No After 28d. Describe how injury occurred 1 Natural 5 Pending iniury Accident Investigation 6 Could not be 24 hours after death Funeral Director: 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the I 3 [Certifying Norse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ure and title Signa certifier 29c. License number 29d. Date signed (Month, Day, Year) 013950 17)- 11/19/2010 and address of erson who co ted cause of death (Item 23a) (Type, Print) Bruce Berger 21 Crossroads Dr. 200 Owings Mills, MD 21117 31. Date filed (Month, Day, Year) State 32. Registrar's Signature NOV 23 Registrar

DHMH 17 Rev 7/2009

For State Registrar	State of Maryland / De
1. Decedent's Name (First, Middle, Last)	

Certificate of Death

4b. City, Town, or Location of Death

RANDAUSTOWN

Physician /Medical **Examiner**

ANNA 4a. Facility Name (If not institution, give street and number) SHTEYNGART

2. Date of Death Day 20 Year 2010 NOVEMBER

4c. County of Death

BALTIMORE

3. Time of Death 1:21 PM

Funeral

Director 28a-f show ō 23a or items

Be Completed by Funeral Director

၉

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "nature any injury or other traumatic event, Ira Madical once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and physician and s the burial-trans s been signed by the attending p should be detached for use as Medical Certification: To Be Completed by After this certificate has funeral director, page 2 s completely filled in by the funeral director,

Division of Vital Records, P.O. Box 68760,

NORTHWEST	HOSPITAL			RAND					BALTIMO	DRE
Social Security Number	6. Sex	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days		r 24 Hrs. Min.	8. Date of Bi	av. Year)		thplace (State or Foreign
217-45-7948 Usual Residence of Dece		93	113.				10/20	/191	/	RUSSIA
	County	10c. Cit	y, Town or Loc	cation						10d. Inside City Limits
MD	BALTIMORE	R	ALTIMOR	DE						1 □Yes 2√2 No
10e. Street and Number	DALITMORE	154	HLI INOI	10f. Zip Code				10a. Cit	izen of What Co	21
	FOOT DRIVE			2120	0			-	USSIA	
11. Marital Status		cedent Ever in U.	S. 13. V			rigin? (Spe	cify Yes or N		14. Race - Am	erican Indian
1 Never Married 2	Armed F ☐ Married 1 ☐ Yes	orces? 2 X7X No	11	Was Decedent of f Yes, specify Cu	ban, Mexic	an, Puerto F	Rican, etc.)		Black, Whit	
3 ☐ Widowed 4 ☐ D	ivorced If Yes, G Year or	aive		I∐Yes 2∏XNo		y:		401 16		WHITE
15. D (Specify onl)	ecedent's Education y highest grade completed)	(Give I	dent's Usual Occi kind of work don DO NOT use retir	during mo	st of workin	g	16b. K	ind of Business	/industry
Elementary/Secondary	(0-12) College	(1-4or 5+)		MEMAKER	64)				OWN HOM	F
17. Father's Name (First, i	Middle, Last)		1101	TLIMKLK	18. Moti	ner's Name	(First, Middle			
VELVEL		NGART				ANA				HEIN
19a. Informant's Name/Re		INOINI	19h Mailin	g Address (Stree	1		l Route Numl	her City o	r Town State	
	TOVA/DAUGHTE	7D	1	OO LIGHT						21209
20a. Method of Disposition				sition (Name of natory or other pla			ate	1	cation - City or	
	nation 3 Removal from	1 State			i	11/21	/2010	ъ	АТ ТТМОР	E MD
4 □ Donation 5 □ C		511		FILOH C . Name and Add		Die .			ALTIMOR	
May				3900 REI		. 5				S., INC. MD 21208
	ease, or complications that re. List only one cause on		n. Do not ente	er the mode of dy	ring, such a	s cardiac o	r respiratory a	arrest,		Approximate Interval Between
Immediate Cause (Final disease or condition	or allot only one outdoo on		Do. I	PHEUN	ALLA					Onset and Death
resulting in death)	aDue to	o (or as a consequ		71001	10,-11					
Commentally list and discount	b									
Sequentially list conditions if any, leading to immediat	e Due to	o (or as a consequ	uence of):							-
that initiated events	С.									
resulting in death) Last	Due to	(or as a consequ	uence of):							
	d									
IF FEMALE:										-
23b. Was decedent pregn in the past 12 months	alle 1 Live	utcome of pregna birth 2 Fetal		Ectopic pregnar	ісу			2	23d. Date of de Month	livery Day Year
1 ☐Yes 2 No	4 ☐ Pre	gnant at time of d mown	eath 5	Other (specify)					MOHUI	Day rear
9 Unknown	andisiana antiibasina ta		JALL - I - AL	ded de e			00 - Did	tobosos :	contribute t	o the cause of death?
Part II. Other significant of				idenying cause g	iven in Pari	1.				
PERIFHER	an Vasculas	L DISEB	St				1 🗆	Yes 2	NO3[_P	robably 4 LUnknown
CORONAR	ARTERY	DISEASI	E				24a. Was		24b. Were a	utopsy findings available completion of cause of
	•						perfe	ormed? 2 ZiNo	death? 1 ☐ Yes	
25. Was case referred to r examiner?	medical				26. Plac	e of Death	(Check only			
1 Yes 2 No	Hospital:	Inpatient 2	ER/Outpatient	t 3 □ DOA Ot	her: 4 🗆 N	lursing Hom	ne 5 🗌 Res	idence	6 □ Other (Spe	ecify)
	Pending (Modification)	of Injury nth, Day, Year)	28b. Time of Injury		ıryat irk? ∃Yes 2.□	_	8d. Describe	how injur	y occurred	
3 Suicide 6	Could not be	e of Injury - At ho	me. farm. stre				Bf. Location /	Street an	d Number or R	ural Route Number,
4 ☐ Homicide		ling, etc. (Specif)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			City or To	wn, State)	
29a. Certifler (Check only one)	ertifying Physician: To the	e best of my know basis of examination	wledge, death tion and/or inv	occurred at the restigation, in my	time, date a opinion, de	and place, a eath occurre	nd due to the d at the time	cause(s , date and) and manner a I place, and due	s stated. e to the cause(s)
29b. Signature and the of	Egrtifie (29c. Licen	se number			29d. Da	te signed (Mont	th, Day, Year)
) Uto	mg mg			Do	0607	293		NOVE	MBER 2	0 2010
30. Name and address of	person who completed cau	ise of death (Item	23a) (Type. P						_	
	IMED, M.D. 5				DANDA	LLSTOW	N ME	2	133	

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / [Department of Health and N	lental Hygiene	
			T = State Registrar	Certificate of Death	Reg. No.	0 36779
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Ye 11-19-2010	3. Time of Death
	Medic	al	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of I	6:07 P M
لمحريب	Examin	er	Gilchrist Hussice	Towson	1 3 1	more
П	Funeral	9,12	5. Social Security Number 6. Sex 7. Age (In yrs. last birt.	hday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth g	Birthplace (State or Foreign Country)
	Director		217 - 24 - 2100	Yrs.	Worth Day, Year) 30	" /nD
	show dat	ro	10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits
	Maryl 28a-f otifie	Director	mo Bal	timore		1 ☑ Yes 2 ☐ No
	th the 3a or t be n	al D	10e. Street and Number	10f. Zip Code	10g. Citizen of Wha	it Country?
	ath wi	Funeral	3400 Franklin Street Art. 11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	American Indian,
ဖွ	or ite	by F	1 Never Married 2 Married Armed Forces?	If Yes, specify Cuban Mexican, Puerto	Rican, etc.) Black, V	White, etc.
803	urs af tural" al Exa	ted	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 ☑No Specify:	Specify: B	lack
15	72 ho n "na" Aedica	Completed	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing 16b. Kind of Busin	ess Industry
21215-0036	within giene. er tha the N		Elementary/Seconday (0-12) College (1-4 or 5+)	Custodian	Ho	tel
p	be filed within 72 hours after death with the Maryland and Hygiene Heal Hygiene ked other than "natural", or items 23a or 28a-f sho ked other than "natural", or items 23a or 28a-f sho cevent, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden Surname)	
Maryland	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If fire 27 is marked other than "natural", or items 23s or 28sa-f sho or other traumatic event, the Medical Examiner must be notified at or other traumatic.	ř	Robert Hamilton	Lueve		n
Z Z	2 should th and Me 27 Is marl traumati		19a Informant's Name/Relationship (Type, Print) 19b 19b 19c	. Mailing Address (Street and Number or Rura		a, Zip Code)
	of Heal of Heal fitem		20a Method of Disposition 20b. Place of	Disposition (Name of	Date 20c. Location - Cit	y or Town, State
Baltimore,	Page nent o ant: If ury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	ry, crematory or other place)	19-2010 Balt	w.mi)
3alti	permit. Page 1 Department of Important: If i any injury or once.		21. Signature of Funeral Service Lice See	2. Name and Address of Facility	Ighn C. Greene	Funeral Services
	<u>00 = 80</u>		23a. Part 1. Enter the disease, or complications that caused the death. Do n	8128 Liberty Rd	. Randa listown n	
			shock, or heart failure. List only one cause on each line.		or respiratory arrest,	Approximate Interval Between Onset and Death
,	nysician/ Medical	100	disease or condition resulting in death) a. Due to (or > a consequence or condition)			years
a opende	Examiner	L	Sequentially list conditions, b.			
	p #	Examiner	if any, leading to immediate Due to (or as a consequence of cause. Enter Underlying	of):		
	be executed sician and burial-transit	Exan	Cause (Uisease or injury that initiated events c. Due to (or as a consequence or peutiting in death) Last	of):	<u>.</u>	
ල :	sician sician buria	dical I	d			
6876	tificate ng phy as the	Med	IF FEMALE:			
9 ×	th cert ttendir or use	ian/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death		23d. Date o	f delivery Day Year
Bo	the a	Physician/Me	1 Yes 2 No 4 Pregnant at time of death 9 Unknown	5 U Other (specify)	World	Day Tour
0	that tr led by detac		Part II. Other significant conditions contributing to death but not resulting i	n the underlying cause given in Part I.	23e. Did tobacco use contribu	te to the cause of death?
Ś.	quires en sigr uld be	Completed by	Emply sema		1 □ Yes 2 □ No 3	Probably 4 🗋 Unknown
COL	aw rec as bee 2 sho	plet		· 	autopsy prior	e autopsy findings available r to completion of cause of
Re	cate h page				1 - 100 - 100	th? Yes 2 🗆 No
ta :	sician: The law is certificate has birector, page 2 s	Be C	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/Ou	26. Place of Death (Check		Home on Y: P
of o	g Physer this eral d	e: To	27. Manner of Death 28a. Date of injury 28b. T	ime of 28c. Injury at	ome 5 Residence 6 20ther (S 28d. Describe how injury occurred	Specify (08) 108
uo :	endine sath. or; Afte he fun	ficat	2 Accident Investigation	njury work? M 1 🗆 Yes 2 🗆 No		
Division of Vital Records, P.O. Box	or Att	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	rm, street, factory, office	28f. Location (Street and Number of City or Town, State)	r Rural Route Number,
	• Hospital or Attending Physician: The law requires that the death certificate be executed the found and expendent. • Funeral Director. After this certificate has been signed by the attending physician and eted filled in by the funeral director, page 2 should be detached for use as the burial-transit	cal	29a. Certifier 1 Sertifying Physician: To the best of my knowledge,	death occured at the time, date and place, an	nd due to the cause(s) and manner a	s stated.
:	To the Hospital or within 24 hours afte To the Funeral Directory completed filled in the Total of the total o	Medical	(Check 2 Medical Examiner: On the basis of examination and/o	r investigation, in my opinion, death occurred a	the time, date and place, and due to	the cause(s) and manner stated.
	Vithi To th		29b. Signature and title of certifier	29c. License number	29d. Date signed (M	
	•		The reternio	D0070635	-	
)			30. Name and address of person who completed cause of death (Item 23a) (nurles St Suite	4105 Baltimor	e, MD ZIZOZI
	Sta	le	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
	Registra	ar	NOV 2 3 2010 Senue . B. Jane			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b Per FH C910 12/02/10 JH State of Maryland / Department of Health and Mental Hygiene All Copies Are Legible. State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street Examiner 4b. City, Town, or Location of Death unty of Death 0. OWSON 8. Date of Birth Funeral 7. Age (In vrs. last birthday) Year If Under 24 Hrs. If Under 1 9. Birthplace (State or Foreign Country) 1 🗆 M 2 🔀 F Months Days Hours Director show should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 23a or 28a-f 1 X Yes 2 No more 10e. Street and Number 10g. Citizen of What Country Funeral 1201 items ; 11 Marital Status 12. Was Decedent Ever Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? 0. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Completed ac permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working (ife. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Sumame) 2 ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signetule of Funeral Service Licensee and Address of Facility

And Greene Name 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Opset and Death Ph, sician/ denocarcycma Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a nonsequence cry the burial-tran Hospital or Attending Physician: The law requires that the death certificate be execu resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) signed by the at d be detached for Pregnant at time of death Month Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed within 24 hours after death.

To the Funeral Director; After this certificate. Yes 2 KNo 1 🗌 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital: 2X No Certificate: To Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 R Other (Specify filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 🔀 Natural 5 Pending injury 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 12125808 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#31perDVR, G909, 11723/2010, WS
State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ eoffrei Medical 2010 ovember 4a. Facility Name (if not **Examiner** tulion, give street and nur 4b. City, Town 4c. County of Death more birthday) 8. Aate of Birth **Funeral** 7. Age (In v If Under If Under 24 Hrs. 9. Birthplace (State or Foreign 1 **X** M 2 □ F Hours Months Min. Day, Year) Country) Director Yrs or items 23a or 28a-f shov 10b. County with the Maryland event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No mor 10e. Street and Numb 10g. Citizen of What Country Funeral death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced a 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done life. DO NOT use retired) during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Meg Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First. ဂ္ 0 19a, Informant's Name/Relationship (Type 19b. Mailing Address (Street and Number of State, Zip Code 20b. Place of Disposition (Name of cemetery, crematory or other p Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 26-2010 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Vaugno Funeral Service 23a. Part 1. Enter ne disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to for as a consoluence of the Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use איז איזייא use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Yes _ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 2 No 3 Probably 4 Unknown Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 24 hours after death.

Funeral Director: After this certificate has autops 1 ☐ Yes 2 ☐ No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ပ 1 🗆 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending injury work? 1 ☐ Yes Accident 2 No Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year) 50 30. Name and add ss of person who completed cause of death (Item 23a) (Type, Print) mp 32. Registrar's 31. Date filed (Month, Qay, Year) State 3°2010 Registrar

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State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NOVEMBER Physician/ ŽĎ, 2010 2:00 AM SILBERSTEIN CONSTANCE Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BALTIMORE BALTIMORE MILFORD MANOR NURSING HOME 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days 1 M 2 TF Hours 09/11/1944 Yrs 66 213-50-6075 **Director** Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-1 sno ner must be notified at Director 1 Yes 2 No BALTIMORE BALTIMORE MD 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral 4204 OLD MILFORD MILL ROAD 21208 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Examiner Black, White, etc. ō ģ 1 Never Married 2 Married 1 ☐ Yes . If Yes, Give Maryland 21215-0036 1 Yes 2 X No Specify: "natural", WHITE 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental F 27 is marked of traumatic ever 2 be WEINER ROSEN LILLIAN PHILLIP 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 5105 AVENUE B, TORRANCE, CA 90505 BARBARA JACOBSON/SISTER Baltimore, item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 듷 cemetery, crematory or other place) 1 🐰 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Department o Important: If any injury or ± 5 BETH JACOB CEMETERY 11/22/2010 FINKSBURG, MD Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Mart Le 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between **Qnset and Death** Immediate Cause (Final Physician/ disease or condition resulting in death) 20 av) Medical Examiner Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Box 68760 attending pl IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month Year 1 Yes 2 No 9 Unknown ed by the a detached f P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s been signe 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has l autopsy performed death? Yes 2 No 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Hospital Other: 2 No ပ္ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Unursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After 1 Natural work? 1 ☐ Yes 2 ☐ No. 5 Pending Investigation Accident 24 hours after deat Funeral Director: □ Accider
 □ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide filled in by determined City or Town, State) Hospital Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifie who completed cause of death (Item 23a) (Type, Print) 30. Name and address of persor 31. Date filed State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

MDHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Robert A. Thomas 0405 am November /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Agnes Baltimore 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Funeral Months Days Year) 1 X M 2 □ F 223-38-4986 Director 75 April 8, 1935 Usual Residence of Decedent 10a State 10b. County show 10c. City. Town or Location 10d. Inside City Limits ?? is marked other than "natural", or items 23a or 28a-f show traumatic event, the Macler Leveniner must be notified at Director MD Baltimore Catonsville 1 ☐ Yes 213 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 719 Maiden Choice Lane BR218 Funeral 21228 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: <u>ک</u> Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any in]ury or other traumatic event, Its Me Montgomery County Elementary/Secondary (0-12) College (1-4or 5+) Guidance Counselor Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clifford Alexander Thomas Irene Margaret Ruppert 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Thomas Wife 719 Maiden Choice Lane BR 218; Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest 12/2/2010 Owings Mills, MD 21. Sign where Tuneral Swine Livens 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc 1630 Edmondson Avenue: Catonsville, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician Muccardia disease or condition resulting in death) 12 hours /Medical Due to (or as a consequence of): Examiner 4 ears Hupertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (J. as a consequence of): Examine law requires that the death certificate be executed aftending physician and for use as the burial-trar Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ≥ sign be 1 ☐ Yes 2 ☐ No 3 ☐ Probably page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy rmed? 2 ☐ No of Vital Yes 2 □ No 1 Yes Hospital or Attending Physician; funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 🗆 Nursing Home 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division 1 Natural
2 Accident (Month, Day, Year) 5 Pending investigation 1 ☐ Yes 2 🗆 No 24 hours after deatl Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only within 2 To the 1 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 22 2010 D41843

DHMH 17 Rev 1/2001

State Registrar Baltimore, Maryland 21229

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

900 S. Caton Avenue

32. Registrar's Signature

10-08889 .

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Jerry Thomas		State of Maryland / Department of Health, and Mental Hygiene Registrar Amend State of Maryland / Department of Health, and Mental Hygiene Registrar Reg. No. 2010 36781
Physic Medical Exam		1. Decedent's Name (First, Middle, Last) Jerry Tyrone Thomas II 2. Date of Death Month Day Year November 19, 2010 3. Time of Death November 19, 2010 3. Time of Death 2316 hrs
		4a. Facility Name (if not institution, give street and number) University Hospital 4b. City, Town, or Location of Death Baltimore 4c. County of Death
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1f Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) 9. Birthplace (State or Foreign Country) 1 Mm 2 F 2 9 Yrs. Months Days Hours Min. 0 9-2 1-1981 Foreign Country) Months Days Hours Min. 0 9-2 1-1981 Foreign Country Months Days Hours Min. 0 9-2 1-1981 Foreign Country Months Days Hours Min. Days Min. Days Hours Min. Days Min.
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th the Maryl 23a or 28a-	al Director	10e. Street and Number 2903 Resbury Street 10f. Zip Code 21216 USA
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. nnt: If item 27 is marked other than "natural", or items 23a or 28a-f shown other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital/Status 12. Was Decedent Ever in U.S. Armed Forces? 1
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MD 21215-0036 d 2 should be filed within ' ith and Mental Hygiene. n 27 is marked other than sumatic event, the Medica	To Be (Terry T. Thomas Rita Tapley 19a. Informant's Nam. Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Baltimore, MD peruit. Pages I and 2 st Department of Health an Important: If item 27 i injury or other trauma		Kta T. Goss - mother 12 Broad bridge Rdi White warsh, mDi 21237 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Baltimore, pernit. Pages I ar Department of Hee Important: If ite		21. Signature of Fungeral S now the nase 22. Name and Address of Facility 270 Fred HILTON Face 22. Name and Address of Facility 270 Fred HILTON Face 22. Name and Address of Facility 270 Fred HILTON Face 22. Name and Address of Facility 270 Fred HILTON Face 22. Name and Address of Facility 270 Fred HILTON Face 23. Name and Address of Facility 270 Fred HILTON Face 24. Donation 5 Other Specify: 25. Name and Address of Facility 270 Fred HILTON Face 26. Name and Address of Facility 270 Fred HILTON Face 27. Name and Address of Facility 270 Fred HILTON Face 28. Name and Address of Facility 270 Fred HILTON Face 29. Name and Address of Facility 270 Fred HILTON Face 20. Name and Address of Facility 270 Fred HILTON Face 20. Name and Address of Facility 270 Fred HILTON Face 20. Name and Address of Facility 270 Fred HILTON Face 20. Name and Address of Facility 270 Fred HILTON Face 20. Name and Address of Facility 270 Fred HILTON Face 20. Name and Address of Facility 270 Fred HILTON Face 20. Name and Address of Facility 270 Fred HILTON Face 20. Name and Address of Facility 270 Fred HILTON Face 20. Name and Address of Facility 270 Fred HILTON Face 20. Name and Address of Facility 270 Fred HILTON Face 20. Name and Address of Facility 270 Fred HILTON Face 20. Name and Address of Facility 270 Fred HILTON Face 20. Name and Address of Face 20. Name and Addre
Physician /Medical Examiner		23a. Den't. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Gunshot Wounds Approximate Interval Between Onset and Death
	e	or condition resulting in death) Due to (or as a consequence of): b. If any, leading to immediate Due to (or as a consequence of):
ed nsit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):
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Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be e 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician rely filled in by the funeral director, page 2 should be detached for use as the bunal	ΣI	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 5 Other (Specify) 9 Unknown
ords, P.O. w requires that the s been signed by should be detach	اھ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sided in by the funeral director, page 2 should be	Completed	24a. Was an autopsy findings available prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
Vital I hysician: this certifi ul director,	ě	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other:
Sion of Attending Pl death. ector: After y the funeral	ertification:	27. Manner of Death 1 Natural 5 Pending Investigation 28a. Date of Injury 28b. Time of Injury 2240 hrs 1 Yes 2 No 28d. Describe how injury occurred Subject shot
Division To the Hospital or Attencythin 24 hours after death To the Funeral Director:	0	3 Suicide 6 Could not be determined (Specify) Outside 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) (Specify) Outside 28e. Certifier A Could not be determined (Specify) Outside 28e. Certifier A Could not be determined (Specify) Outside 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 1500 Poplar Grove Street, Baltimore, MD
To the rithin To the comple	edica	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
(3)		O.C.M.E. November 20, 2010
1		Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
St Regist		31. Date filed (Month, Day, Year) Registrar's Signature
DHMH 17 Rev 1/20 OCME 2006	001	OCME ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death Month Physician/ 2010 1020 AM Rodney F. Toliver Medical 4a Facility Name (if not institution, give street and number) Examiner 4b_City, Town, or Location of Death 4c. County of Death Baltimore Baltimore N/A ttosni 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 M 2 □ F Months Hours 03977277955 Maryland 55 **Director** 218-62-3012 Usual Residence of Decedent 23a or 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No Baltimore MD N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4800 Seton Drive 21215 U.S.A. , or items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 31 and 2 should be filed within /z menocolof Health and Mental Hygiene.
If item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced Completed Black Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Grade Crane Operator Sparrow Point Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) 2 Thelma Delores Thomas Johnny James Toliver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 2; any injury or other to 3042 Matthews St., Baltimore, MD 21218 Johnnetta Toliver(sister) 20b. Place of Disposition (Name of 20c. Location - City or Town, State Josephrenstrown Pr And Crematory 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/24/10 Baltimore, MD Signature of Funeral Service Licensee 22JosephdreHof Fagirown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 iamo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Peath Immediate Cause (Final Physician/ SE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. -transit Due to (or as a consequence of resulting in death) Last burialthe attending physician hed for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 Yes 2 No þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. To the Funeral Director: After this certificate has been signed completed filled in by the funeral director, page 2 should be detected filled in by the funeral director, page 2 should be detected filled in by the funeral director, page 2 should be detected. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 N 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 **V** No မှ 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred injury Natural 5 Pending after death Director: / Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the F only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month NOVEMBER ROBERT THOMPSON Medical 9:15AM 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 578-16-9521 1 X M 2 | F Hours 1 1 / 29 / 1 9 2 4 Director 85 Usual Residence of Decedent shov 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Frederick MD Mt. Airy 1 Tyes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 72 hours after death with 5797 Catoctin Vista Drive 21771 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces' Yes 2 NoWW Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Guard Specify: "natural", Completed 3 Divorced Year or Dates. Coas t Specify: White other traumatic event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 10 Foreman Utilities Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Orville Douglas Thompson Gladys M. Sparrow 19a. Informant's Name/Relationship (Type, Print) Barbara Lee Thompson/Wife ing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catoctin Vista Dr., Mt.Airy, MD 21771 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State remetery, crematory or other place)
Final Journey Crem. 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 11/23/2010 Woodbine, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Eacility Po Box 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death INTRACRANIAL HEMMURHAGE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner THRUMBUCYTUPENIA Esquantiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) LEUKEMIA death certificate be executed the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 attending pr IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Dav Year 2 🗌 No ed by the a Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. To the Hospital or Attending Physician: The law requires that within 24 hours after death.

To the Funeral Director: After this certificate has been signed completed filled in by the funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed' 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DUUG3498 11/21/10 147 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lakhvinder Wadhwa, M.D., 400 West 7th Street, Frederick, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar

NOV 23 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day TAYLOR Medical SHIRLEY NOVEMBER 2010 5:20 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S HOSPITAL CHEVERLY PRINCE GEORGE'S Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1 □ M 2 □ **X**F 579-42-2726 Months Days Hours Min. 78 Country Director APRTI. 1932 PENNSYLVANTA Usual Residence of Decedent show 10a. State 10c. City, Town or Location death with the Maryland at Director 10d, Inside City Limits ral", or items 23a or 28a-f s Examiner must be notified DC WASHINGTON 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2113 MARYLAND AVENUE N.E. 20002 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc 1 \square Never Married 2 \square Married þ 72 hours after Baltimore, Maryland 21215-0036 BLACK If Yes, Give 1 Yes 2 No Specify: "natural" 3 Widowed 4 Divorced Completed Year or Dates and Mental Hygiene.

is marked other than "naturraumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) 12TH ermit. Page 1 and 2 should be filed wi epartment of Health and Mental Hygie aportant: If item 27 is marked other by injury or other traumatic event, the POSTAL WORKER GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ CHARLES DIGGS KATHRYN WHITE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JUANITA DIGGS/DAUGHTER 2113 MARYLAND AVENUE N.E. #10 WASHINGTON, DC 20002 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a Department of I-Important: If ite any injury or ot 20c. Location - City or Town, State Date 1 Durial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) RIVERDALE CREMATORY 11/18/2010 RIVERDALE, MARYLAND Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. OAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death ₽nysician/ SEPTIC SHOCK disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) sician and burial-transit RESPIRATORY FAILURE that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending above. Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day 1 Yes 2 1 signed by the a 2 X No 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed?

Yes 2 No death?
1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: မ 1 Tes 2 No 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending (Month, Day, Year) s after death. Accident 1 Yes 2 No Investigation 2 Accider
3 Suicide completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined building, etc. (Specify) Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature 29c. License number 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OPHNELL CUMBERBATCH M.D. 8416 CENTRAL AVENUE LANDOVER, MARYLAND 20785 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mildred Taylor 8:00 A M November 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3569 Ft. Meade Road, #303 Laurel Anne Arundel If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country), Georgia 253540112388 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year, June 15, 1 Months Days Hours Min Director 257-34-0234 Ĩ925 Usual Residence of Decedent 28a-f show 10a. State Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 V No MD Anne Arundel Laurel 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? 23a (Funeral 3569 Ft. Meade Road, #303 20724 USA items Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. Fant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 African If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Completed 3 X Widowed 4 Divorced American the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8th Sales Clerk Post Exchange Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Wilbert M. Jones Lucy Cravers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley A. Hutchinson/Daughter 3050 Cherry Lake Road, Indianapolis, IN 46235 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Arlington Nat'al 12/21/2010 Arlington, VA 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Donaldson Funeral Home, P.A. M01103 313 Talbott Avenue, Laurel, MD 20707 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ₽nysician/ Medical Examiner an Sequentially list conditions, if any leading to immedicause. Enter Underlying Exam Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury signed by the attending physician and d be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death Month Dav Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed been a 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy After this certificate 2X No Yes 2 XNo 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Other: ျ 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work 1 Tyes 2 🗌 No 24 hours after death Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1- Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the I only one 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) of death (Item 23a) (Type, Print) 30. Name and a ess of person who completed caus V 2480 Clewelle Port Meade 20155

State

Registrar

31. Date filed (Month,

NOV 23

32. Reg

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dorothy LaRue Tracey 2010 9:50 a M November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Marley Neck Health & Rehab Center Glen Burnie Anne Arundel 5. Social Security Number 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 1 M 2 K F Months Days Hours Min. (Month, Day, Yea Director 213-28-1349 86 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 🗆 Yes 2 🙀 No MD Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 300 Salony Drive Apt 203 21136 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. o. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify "natural" Completed 3 Widowed 4 Divorced White permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Black and Decker 10 Cafeteria Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Sarah Susan Sterner John William Cape 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13 Stafford Road Rehobeth, DE 19971 Shirley T. Miller Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 11/17/10 Finksburg, Maryland Evergreen Mem Gardens <u>of Fun</u>eral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, MD 21136 23a. Part 1. Entay the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval B shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): CARDIONASCULAR DISEASE **Examiner** ARTERIO-SCLEFOTIC Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregna 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year should be detached g Unknown g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an · has page 2 performed this certificate 2 No 1 TYes funeral director, 25. Was case referred to recical 26. Place of Death (Prieck only one) Be examiner? Hospital 2 NO Other: 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer (Month, Day, Year) 1 Natural 5 Pending injury 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature a d title of certifie 29c. License number 1 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOV. 22^{ay} 2010 5:30 Ам Olga Marini De Vergne Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Columbia Vantage House 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days (Month, Day, Hours Min. Puerto Rico 1 🗆 M 2 😾 F Yrs. 916 **Director** 584-30-1902 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 🗌 Yes 2 🛛 No Columbia Howard 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21044 5400 Vantage Pt. Rd. AspenHC-409 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married Yes 2 No þ Baltimore, Maryland 21215-0036 within 72 hours after 1 x Yes 2 □ No Specify: Puerto Rican Specify: Puerto Rican If Yes, Give 3 😾 Widowed 4 🗌 Divorced Completed Year or Dates 16a Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event the Manay injury or other traumatic event the Manay injury or other traumatic event the Manay injury or other traumatic Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Josefina Fagundo ပ Luis E. Marini 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7536 Broken Staff, Columbia, MD 21045 Ada Vergne-Marini / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Metro Crematory Inc 11/23/2010 22. Name and Address of Facility Cremation Society of Maryland 21. Signature of Funeral Service Licensee Alyson Taylor 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Weeks Immediate Cause (Final Cerebral Vascular Accident Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Hypertension years Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a consequence of sician and burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria by Physician/Medical death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Day in the past 12 menths?
1 Yes 2 No
9 Unknown Month Pregnant at time of death ned by the a 9 Unknown or Attending Physician: The law requires that the a after death. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown þe Atrial Fibrillation Division of Vital Records, Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b lirector, page 2 s autopsy performed? Yes 2 ☑ No 2 🗌 No 1 Yes 26. Place of Death (Check only one) funeral director. 25. Was case referred to medical examiner? Other: Hospital 2 🗹 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completed filled in by the formula to t Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie November 22 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November Day 9. 2010 John Frank VonHage1 5:20 a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Dulaney Valley Assisted Living Baldwin 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1 **X** M 2 □ F Months June, 24 Year 1917 Maryland 216-16-8578 90 **Director** Usual Residence of Decedent 28a-f shov ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 ☐ Yes 2X No Maryland Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21286 1621 Feldbrook Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 X Never Married 2 Married 1 ☐ Yes 2 ☐ KNo If Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White "natural" Completed 3 Divorced 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor of Ushers Ballpark Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, 1 and 2 should be find Health and Mental 2 John VonHage1 Joseph Anna Frank 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Moore (Per. Rep.) 1621 Feldbrook Rd., Towson, MD 21286 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot cemetery, crematory or other place)
Loudon Park Cemetery 11/22/10 1 Burial 2 Cremation 3 Removal from State Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service License 3620 Wilkens Ave., Baltimore, MD 21229 231 Fart + Emier the issease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause or Interval Between Immediate Cause (Final disease or condition Onsut and IRATIO Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a cons, quence of and -transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a cor sequence of the burial attending physician Physician/Medical P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) 23d. Date of delivery 1 Live Birth 2 Live 3 1 4 Pregnant at time of death jo in the past 12 months? Month Yes 2 No within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy perform Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 잍 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 56XAD 1-20

MDHMH 17 Rev 7/2009

State Registrar

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oger Volland,	Jr.	1- For State Registrar	tate of Maryla		rtificate d		na iviei	ılaı nyç		Reg. No		36792
Physici odical Exam		Decedent's Name (First, Middle Roger V. Vol. Aa. Facility Name (if not institution)							Date of Do Month Novemb	Day er 14,		3. Time of Death 1416 hrs
		4a. Facility Name (if not institution University Hospital	on, give street and n	umber)		4b. City, Town, Baltimore		of Death		4	c. County of Dea	ath
Funeral Director		5. Social Security Number	6. Sex	7, Age (In yrs.		If Under 1 Y	ear If Und				Fore	Birthplace (State or eign
		218-21-8374 Usual Residence of Decedent	1 M 2 F	24					11/0	07/19	986 Ma	Aryland
d how any		MD Ca	lvert	10c. City	T , Town or Loca	ation 1Sby						10d. Inside City Limits 1 Yes 2 No
Marylan Marylan 28a-f sl	Director	10e. Street and Number	iiveit	-	П	10f. Zip Code				10g. Cit	tizen of What Co	puntry?
r death with the Maryland or items 23a or 28a-f show must be notified at once.		650 Running Fo	x Road	cedent Ever in U	l.S. 13. W	2 ras Decedent of I	0657 Hispanic Ori	igin? (Spec	ify Yes or I	No-	USA 14. Race - Am	encan Indian, Black,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with file Max) Department of Health and Mental Hygiene. Important: If time X7 is marked other than "natural", or items 23a or 28a injury or other traumatic event, the Medical Examiner must be notified at	Funeral	1 Never Married 2 MM 3 Widowed 4 Div	Armed F 1 Yes Vorced If Yes, Give Ye	2 🔀 No	lf 1	Yes, specify Cub			can, etc.)		White, etc.	√hite
hours aft natural" Azamine	ed by	15. Decedent's Education (Spe	or Dates: ecify only highest gra	de completed)		ent's Usual Occup	pation (Give	e kind of wor		16b.	Kind of Busines	
036 Ithin 72 ne. r than "	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	Comm	nercial	Elect:	rician	n.	K	elly Ele	ectric
21215-0036 wald be filed within 7 Mental Hygiene, marked other than c event, the Medica	17. Father's Name (First, Middle, Last) Roger V. Volland, Sr. 18. Mother's Name (First, Middle, Maiden Surname) Joann L. Ringler											
212 thould be nd Ment is mark	Roger V. Volland, Sr. Joann L. Kingler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z Roger V. Volland, Sr. / Father 650 Running Fox Road Lusby, Maryland 206											
Baltimore, MD permit. Pages I and 2 sh Oepartment of Health and Important: If item 27 is injury or other traumati	- 3	Roger V. Volla	-	20b.		sition (Name of		oad l	usby .	, Ma:	ryland 2 Location - City	2065 / or Town, State
imor Pages ment of tant: If	2	1 Burial 2 Cremation 4 Donation 5 Other S	pecify:		estlawr	Mem. P	ark	11/1	19/10	Ma:	rroitts	ville, MD
Balt permit Depart Impor injury		21. Signature of Funeral Service	Licensee	-h		Name and Address						Home nd 21229
Physician Medical	7	23a. Part I Enter the disease or failure. List only one cause Immediate Cause (Final disease	complications that con each line.	aused the death mplicat Alcohol	i Do not enter	the mode of dyir Probab	le Mi	cardiac or re xed Di nd Nau	espiratory a	errest, sh	ock, or heart ication	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)		consequence of		obable	lxycor	done_I	nrox	Car	LOIL	
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		a consequence of	•							
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8760, ifficate be eng physician is the burial	sician/Medica	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes,	outcome of preg	inancy	etal death		ic pregnanc			Bd. Date of delive	ery Day Year
30x 68 death certil e attending for use as	ysicia	past 12 months? 1 Yes 2 No 9 Uni	4 Pregi	nant at time of de own		Other (Specify)				-		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwitin 24 hours after death. To the Funeral Increors. After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial.	by Phy	Part II. Other significant condit	tions contributing t	o death but not r	esulting in the	underlying caus	e given in P	Part I.		_		to the cause of death?
ords, I w requires s been sig should be	ompleted						-		24a. Wa		24b. Were	autopsy findings available o completion of cause of
Reco The law icate has	Comp								per 1 ✓ Yes	formed?	death	_
Vital Rec ysician: The his certificate director, page	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No		Inpatient 2	ER/Outpatier		-	(Check onl		Resid	ence 6 Oth	ner:
n of \india Phy. h. After the funeral		27. Manner of Death 1 Natural 5 Pend	28a. Date (Month	of Injury n. Day, Year) 2010	28b. Time of 0900 hrs	· · · 1 _	yes 2 🕱	r No	_		jury occurred	-
ivision or Attene after death Director:	Certification:	2 Accident Inver	stigation 28e. Plac			eet, factory, office	e building, e		unkno 3f. Location or Town	(Street	and Number or I	Rural Route Number, City
Divis: To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by		4 Homicide	hysician: To the be			in Vehicurred at the time,			304 Sittin	g Bulí T	rail, Lusby, M	
To the within 2 To the complet	Medical	one) 2 Medical Exa	miner:On the basis and manner:	of examination a	and/or investig	ation, in my opini	on, death o	ccurred at the	he time, da	te and pl	ace, and due to	the cause(s) fonth, Day, Year)
	<	29b. Signature and title of certific	WILL MA				C.M.E.	•		1	101/ /5	- +# 201h
		30. Name and address of person Assistant Medical		· ·		re, MD 2120	1			1717	<u> </u>	
	toto	31. Date filed (Month, Day, Year)		egistrar's Signat		3						

DHMH 17 Rev 1/2001 OCME 2006

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1 - For State Registrar	State of Maryla		Certificate of		, ,	g. No. U I II	36793
Physic	cian	1. Decedent's Name (First, Middle, Las	BYRON		VICKE	RY	2. Date of Death Month	Day Year	3. Time of Death O 4:35 A M
/Med Exam		4a. Facility Name (If not institution, giver HARBOR HOSE				r Location of Death	November	4c. County of Dea	
Funera Directo		Social Security Number 6. S			Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, March 25,		rthplace (State or Foreign country) ryland
Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland	N/A 10c. C	City, Town o		ltimore			10d. Inside City Limits 1X Yes 2 □ No
th with the 23a or 28	Funeral Director	10e. Street and Number 406 Fran	kle Street		10f. Zip Code	21225	10	g. Citizen of What C	ountry?
Deficiency in the yield of the Develop operation. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Engineer must be notified at mone.	þ	11. Marital Status 1 Never Married 2 A Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	U.S.	13. Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 🙀 No	dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- pecify Yes or No- pecify Yes or No-	14. Race - Am Black, Whi	
within 72 he ene. than "natu	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5+)	- (G	ecedent's Usual Occup Give kind of work done fe. DO NOT use retired NOO1 Teacher	durina most of worl	king E	66. Kind of Business Baltimore Ci Board of Edu	ty
id be filed fental Hygi rked other	To Be Co	17. Father's Name (First, Middle, Last) Curtis A				18. Mother's Nam	ne (First, Middle, Ma	aiden Surname) Lanford	
and 2 shouealth and Mark		19a. Informant's Name/Relationship (Barbara Ann Vickery	Type. Print) (Wife)		failing Address (Street)6 Frankle St			-	Zip Code)
Pages 1 ament of He ant; If item ury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif.	Hemoval from State		isposition (Name of crematory or other place 11 Cemetery	ce) 11/22	-	Oc. Location - City o	
permit. Departr Importa any inje		21. Signature of Fungral Service Licer	see Kevin E Ecke	r	22. Name and Addre		Cully-Poly, Baltimore	miak Funera e, Md. 2122	al Home, P.A. 25-1856
Physician /Medical		23a. Pa 11. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the decone cause on each line. a	, E	coli B	ng, such as cardiac	,	st,	Approximate Interval Between Onset and Death 7-/0days
rificate be executed XIII and III and III and III as the burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conse	equence of)	imphocy			ia	>5 years
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time o 9 Unknown	tai death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify)			23d. Date of d Month	
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I or Attendi a after death. I Director: A d in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		home, farm		Yes 2 □No	28f. Location (Stre City or Town,	eet and Number or I State)	Rural Route Number,
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To th within To th comp	Me	29b. Signature and title of certifier	8		29c. Licens	Sool	29	d. Date signed (Mor	nth, Day, Year) PER 17,2010
		30. Name and address of person who JAY ZAN DULAM 31. Date filed (Month, Day, Year)	Completed cause of death (Its NATSAG 3 32. Registrar's Sign	em 23a) (Ty	over Hana	over Str	eet, Ba	Himore,	MD 21225
Si Regis	tate trar	NOV 23 2010	Jz. negistrar s Sig	S C	W. Sand				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dav Year WASH, TUDO 4 (.M. GENALDIDE 2010 11 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore M'Ladies Pikesville Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 216.34.0068 1 🗆 M 2 🗙 F Hours (Month, Day, **Director** MD Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County be filed within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits Baltimore HKesville MI) 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3904 M'Ladies Funeral $(\lambda$ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Was Deceden.
Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Black Specify: Completed 3 Widowed 4 Divorced : If item 27 is marked other than "natur or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than Elementary/Seconday (0-12) Hospice GNA Be 17. Father's Name First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lorenzo Sylvester Constance Mae Lewis permit. Page 1 and 2 should be Department of Health and Mer Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melvin S. Washington/ trustand 3904M'Ladio Court Plesville MD 21208 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Chinas Mills, MD 12/02/2010 4 ☐ Donation 5 ☐ Other (Specify) GULLISON. tovest . Signature of Funeral Sewice Licenses 22. Name and Address of Facility Qugen C. Greene Funcial Services Road Landallotonn MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death METASTAMIL BREAST CENCEN Ph_sician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) signed by the attending physician and deed be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 124 hours after death.

• Funeral Director: After this certificate has autopsy performed? Yes 2 No 1 🗌 Yes 2 No ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 🛛 Other (Specify) 2 X No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 D Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10018320 11/23/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FIT 10753 ralls Ry. いてけんつうしん ガイ 21093

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Yeal)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Leo Charles Weber 4:10 PM ,2010 Medical Novembe 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Min. 1 🛛 M 2 🗆 F Months Days Hours **Director** 214-84-7823 02411-24.982 Country Usual Residence of Deceden show or 28a-f shov notified at 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Harford Bel Air 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o edical Examiner must be Funeral 2303 Chantaway Ct 21015 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married ģ 1 ☐ Yes 2 🜠 No If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 Divorced 4 Divorced the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Clinical Pharmacist Medical marked other Be 17. Father's Name (First, Middle, Last) h and Mental F 7 is marked of 18. Mother's Name (First, Middle, Maiden Surname) မ Leo Bernard Weber Loretta Mary Sarzynska or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa K. Weber (Wife) 2303 Chantaway Ct BEl Air, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place permit. Page 1 a
Department of h
Important: If ite
any injury or otl 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 D Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-22-2010 Bayview Crematory Baltimore, MD 21. Signature of Funeral Service licensee 22. Name and Address of Facility Schimunek Funeral Home of BelAir Inc 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Acute Ischemic disease or condition nours Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾| 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy performed?

Yes 2 No death? Hypertension 1 ☐ Yes 2 ☐ No 25. se referred to medical Be 26. Place of Death (Check only one) examiner? ျှ 2 🗌 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 🗌 Yeş 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

of Vital Records. 03 . Veber To the Hospital or Atte within 24 hours after de To the Funeral Directol completed filled in by the

State

only one)

31. Date filed (Month,

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Re

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P0053568

500

4a. Facility Name (**Examiner** Union N 5. Social Security Funeral Director 219-30-Usual Residence of permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State Director MD 10e. Street and Nu Funeral 2440 E 11. Marital Status 1 Never Ma Be Completed by Baltimore, Maryland 21215-0036 3 - Widowed (Sp Elementary/Se 9th Gr 17. Father's Name ည William 19a. Informant's I Janet 20a. Method of Di 1 🔲 Burial 21. Signature of F 23a. Part 1. Ente shock, or he Immediate Cause disease or condit resulting in death Physician/ Medical **Examiner** Sequentially list of if any, leading to Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease of that initiated ever resulting in death Medical Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decede in the past 1 1 Yes 2 Part II. Other sign 25. Was case reference examiner?

1 Yes 2 27. Manner of De Natural 2 Accident
3 Suicide
4 Homicid

for State Registrar

Physician/

Medical

1. Decedent's Name (First, Middle, Last)

, Decedent's Name	e (First, Middle	s, Last)							Month	D	ay	Year	1 1 1 4 4	
	osina								Month	20	2 2	2010	6:40 A	M
		, give street and nun			4	b. City, Town, or				40	-	of Death		
Union M	lemori	al Hospi	tal	um land hiethol	014	Balti If Under 1 Year			8. Date of Bir	th	- IN	/A	place (State or Fore	ian
. Social Security N 219-30-	0541	6. Sex 1 ☐ M 2 ☐ F		yrs. last birthd.	-// N	Months Days	Hours	Min.	0/8/11		17		yland	9"
Jsual Residence of 0a. State	Decedent 10b. County		100	:. City, Town o	r Locat	ion							10d. Inside City Lim	its
MD	N/	7\	İ		F	Baltimo	re						1 🔀 Yes 2 🗌	No
0e. Street and Nur		A				10f. Zip Code				10g. C	itizen of	What Cou	ntry?	
2440 E	Fave	tte Stre	eet.			212	24				U.	S.A.		
1. Marital Status	rajo	12. Was Dece	edent Ever i	n U.S.	13. Wa	s Decedent of Hi	spanic O	rigin? (Spe	cify Yes or No-			e - Americk, White,	can Indian,	
1 Never Marr		If Vec Giv	2 No			Yes 2X No			, , , , , ,		Specify			
3 Widowed		Year or D		1	_							B	Lack	
(Spe		ent's Education est grade completed)	(6	ive kin	it's Usual Occup d of work done o VOT use retired)	ation luring mo	st of worki	ing	160.	Kina of B	usiness Ir	igustry	
Elementary/Sec 9th Gra		College (1	-4 or 5+)	Day		Nork(ho	use	Kee	per)	Mr.	&Mr	s. I	alondo_	
7. Father's Name		Last)		1247					e (First, Middle					
Villiam	Clint	con					Cel	ecia	unk					
19a. Informant's N				19b. ħ	Mailing	Address (Street	and Numi	ber or Rura	al Route Numb	er, City o	or Town, S	State, Zip	Code)	
Janet V	West(Granddau				E. Fay	yett	e St	reet,					
20a. Method of Dis	position	3 Removal from		Oh Place of D	isposit crema	ion (Name of Lory or other parts	≱н	11/2	9°/,1,0	1		•	own, State	
4 Donation			7	And Cr		rowther the atory		11/0	4/10			nore		
21. Signature of Fu	uneral Service	Licensee	illu	am	22 J 21	oseph 40 N. 1	for Fagi Fult	rown on A	Jr. ve.,B	Fun alt	era] imor	L Ho	me PA D 21217	
23a. Part 1. Enter	the disease, o	or complications that	caused the	death. Do not	_			_					Approximate Interval Between	
shock, or hea Immediate Cause	art failure. List (Final	only one cause on e	ach line.										Onset and Death	
disease or condition resulting in death)		a. Due to	(rasacor	nsequence of)	:									
		Pa	eumo	116									6 days	
Sequentially list or if any, leading to it	mmediate	Due to	(or as a cor	nsequence of)	:	12 21							21	
Cause (Disease or that initiated even	r iinjury	c. Ur	inary	Tract	1	n fection	1					-	Saays	
resulting in death)		Due to	(or as a co	nsequence of)	:									
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IF FEMALE:		230 If yes ou	itcome of n	regnancy							004 0	ate of deli	uon/	
23b. Was deceden in the past 12	months?	1 Live	Birth 2	Fetal death	3 🗌	Ectopic pregnand	су					onth	Day Year	
1 Yes 2		9 🗌 Unk		ie or death	0 🗀	Ottion (opecary) _								
Part II. Other sign	ificant condit	ions contributing to	death but ne	ot resulting in	the un	derlying cause gi	ven in Pa	rt I.	23e. Did	tobacco	use con	tribute to	the cause of death?	
									1 🗆	Yes	2 X No	3 🗆 Pr	obably 4 🗆 Unkn	own
									24a. Wa		24b.	Were aut	opsy findings availa ompletion of cause	ble
									aut per	opsy formed s 2	No	death?	2 No	J1
25. Was case refer	rred to medica	1	-			26. P	lace of De	eath (Chec	k only one)	, _ =	140	, 103		
examiner?	⊠ No	Hospital:	Inpatient	2 ER/Out	patient	3 □ DOA Oth	er: 4 🗆	Nursing H	ome 5 🗆 Res	sidence	6 □ Oti	ner (Speci	fy)	
27. Manner of Dea		28a. Date	e of injury nth, Day, Ye	28b. Tir		28c. Injui wor	ry at		28d. Describe					
1 Natural 2 Accident		tigation					Yes 2	□ No						
3 Suicide 4 Homicide	6 ∐ Coul deter	28e. Plac	e of Injury - ding, etc. (S	At home, farn pecify)	n, stree	t, factory, office			28f. Location City or To			ber or Run	al Route Number,	
M.								1	at don't all		and -	nor	tod	
(Chaol:	2 Madical	ng Physician: To the Examiner: On the bang Nurse Practioner	seie of evam	ination and/or	investic	ration, in my opini	ion, death	occurred a	at the time, date	and pla	ice, and di	ue to tne c	ause(s) and manner	stated
29b. Signature and			1			29c. Licens	e numbe	r				ed (Month	, Day, Year)	
> m	mm	1 12	1	MD	P	302	438	946		N	OV.	20,_	2010	
30. Name and add MICHAEL	1 0.1	n who completed call	use of death	Fe St.	pe, Pri	nt) Galtimo	re;	MD	212	3/				
31. Date filed (Mor	nth, Day, Year)	h 32.	Registrar's	Signature	1									
MAN	<u> </u>	- Andrew	1											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#20b perFH, G909 11/23/2010, WS
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No

3. Time of Death

2. Date of Death

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			Registrar 1. Decedent's Name	/First Middle I a	et)			lilicale of	Dealli	2. Date of D	Reg. No)	3	7 0 7
	Physic /Medi			y West	51/					Month	Da I			3. Time of Death /
and.	Exami		4a. Facility Name (In	not institution, giv	re street and number)			4b. City, Town, o	or Location of Dea	ith	4c	. County of D		
and the		49-4		aritan H	ospital				imore			N/A		
	Funeral Director		5. Social Security No. 499–36–8	020	DM AVE	e (In yrs. Ia 76	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		irth <i>Day, Year)</i> 2 , 1 .	934 St	Countr	ace (State or Foreign ry) cuis, MO
	and w		Usual Residence of 10a, State	Decedent 10b. County		10c City	Town or Lo	cation					10	d. Inside City Limits
	/aryla	ō		•		,		cation					100	1 □Yes 2 □tho
	the N	Director	Maryland 10e. Street and Nun	Baltimore		Park	<i>i</i> lle	10f. Zip Code			10a Ci	tizen of What	Countr	**
	with 3a or			lewood A	venue			21234						
	death ms 2	Funeral	11. Marital Status		12. Was Decedent	Ever in U.S.	13. \	Vas Decedent of F f Yes, specify Cub	Hispanic Origin? (Specify Yes or N		ted Sta		
altimore, Maryland 21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Modical Exercitrus the notified at	þ	1 □ Never Marrie		Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	No		fYes, specify Cub I∐Yes 21X∏No	an, Mexican, Pue Specify:	rto Rican, etc.)		Black, W		c.
2-0	72 ho natur	Completed	(Spec	15. Decedent's Edify only highest gra	ducation			lent's Usual Occup		arkina	16b. K	(ind of Busine	ss/Indu	ıstry
121	ithin ne. han "	ם	Elementary/Secon		College (1-4or 5	i+)	life. L	DO NOT use retired	d)	orking .				
7	T (1) -		17. Father's Name (First Middle Last	N/A		Hom	emaker	40 Mails and Ma	ame (First, Middle		At Home	<u>:</u>	
ano	e d to	Be	Frank]		,							i Surriame)		
₹	2 should by and Menta is marked aumatic er	욘	19a. Informant's Na		Type Print)		19b Mailin	g Address (Street		n Petra		ar Town State	a Zin (Code)
M	ges 1 and 2 should it of Health and Mer If item 27 is marke or other traumatic			. ,	/Daught						-		-	
ē,	s 1 al of Hez item othe		20a. Method of Disp		/ Daugire		ce of Dispo	Rona C sition (Name of natory or other place		Date	20c. L	ocation - City	or Tow	n, State
Ë	Pages nent of ant: If its ury or o			Cremation 3 ☐ 5 ☐ Other (Specif	Removal from State	1		Cemetery Cemetery	11000	ember 2010	Dar	ekrai 110	N/I	aryland
alti	permit. Pages Department of Important: If i any Injury or once.		21. Signature of Fur			1		. Name and Addre	ss of Facility					
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			23a. Part 1. Enter t shock, or hea	e disease, or com t failure. List only	plications that caused one cause on each lir	the death.	Do not ente	er the mode of dyin	ng, such as cardia	ac or respiratory	arrest,		- 1	Approximate nterval Between
4	Physician		Immediate Cause disease or condition	hatl	BRAI	_			MCNor					Onset and Death こい Hours
	/Medical Examiner		resulting in death)		Due to (or as		,			16 6	2			
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11	rted nsit	in	if any, leading to immoduse. Enter Under Cause (Disease or in that initiated events	hediate lying niury	Due to (or as	a conseque	nce ot):		M.E.	DIGHT 1			5	DAYS
,	exection and and al-tra	Examiner	that initiated events resulting in death) L	ast	c. Due to (or as	a conseque	nce of):		A A BENTYED B.	///			-	01173
8760,	ficate be executed physician and s the burial-transit	dical			. d.			WIFEETER	A TOM A					
	rtifica ng ph as th	Medi						- 6	<i>/</i> / <i>·</i>			-37/7////	10-11-1	
Вох	th ce tendii r use	Physician/Me	IF FEMALE: 23b. Was decedent		23c. If yes, outcome 1 Live birth			Ectopic pregnanc			1	23d. Date of		
0.	ie dea the at	sici	in the past 12 r 1 ☐ Yes 2 ☑ 9 ☐ Unknown	No No	4 ☐ Pregnant at 9 ☐ Unknown			Other (specify) _	,			Month	D	ay Year
o.	that the death certifi ed by the attending detached for use as	F.		cant conditions of	ontributing to death bu	it not resulti	ng in the un	derlying cause giv	on in Port I	23e Did	tobacco	use contribute	to the	cause of death?
ds,	w requires that s been signed b should be deta	d by	. a.c cc. c.g.		onabuling to death be	at not result	ing in the un	denying cause giv	en in rait i.					bly 4 Unknown
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Be	he lav e has ge 2	E C								24a. Was auto		24b. Were prior t death	o com	sy findings available pletion of cause of
<u>ta</u>	sician: The law certificate has t irector, page 2 s		25. Was case referre	ed to medical	· · · ·	···			00 Plans - 1 P	1 □ Yes	2 □ No	1 🗆 Y	es 2	□No
Division of Vital Records,	yslck is cer direct	o Be	examiner? 1⊠Yes 2□1	ł	Hospital: 1 Inpatie	nt 2□El	R/Outpatien	t 3 DOA Oth	or.	eath <i>(Check only :</i> Home 5 Res		6 □Other /S	naoihi)	
0	ding Phys n. After this funeral di	Certification: To	27. Manner of Death 1 ☐ Natural	5 Pending	28a. Date of Inju	ry 2	8b. Time of Injury	28c. Injur Work	y at	28d. Describe	how injur	ry occurred		NO FELL
Sio	eath. eath. or; A	catic	2 Accident	investigation	11/9/1	0		PM 10	Yes 2. ☑No	HITTI	NG	MEL	2 7	HEAP.
<u> </u>	or Att fter d lirect n by t	T I	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of Inju- building, etc	iry - At hom c. <i>(Specify)</i>	e, farm, stre	et, factory, office		28f. Location (City or To	wn. State	ヨ) フラフィ	2 12	V C. C JANO
	pital ours a sral C		20- 0-455-	15 / 111 / 11		Hor	- Davis			ANE , I	HRKY	VILLE.	ME)
	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death, within 24 hours after death, to the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	one)	2∐ Medical Exan	ysician: To the best on niner: On the basis of and manner sta	f examination ted.	edge, death n and/or inv	estigation, in my o	ppinion, death occ	ce, and due to the curred at the time	, date and	d place, and d	ue to t	he cause(s)
	5 <u>¥ 6</u> 8		29b. Signature and ti	de of certifier	INTERN		MEP	29c. Licens				ite signed <i>(Mo</i>		**
			20 November 1	1241	RESIDE				3000			11/22	12	010
	Ш		0 0		completed cause of de									
	Sta	te	31. Date filed (Month	Day, Year)	32, Registra	ar's Signatur	e <u>roct</u>	Raven B	oulevard	l,Baltim	ore :	Maryla	nd⊸	21239
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 0.37PM ame (if not institution, give street and number) 4c, County of Death 4b. City, Town, or Location of Death OWSON last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Hours Min Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Specify: B/acK 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Father's Name (First, Middle, Last) 18_Mother's Name (First, Middle, Maiden Surname) lells Howard 9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, ematory or other place) 1 Durial 2 Cremation 3 Removal from State ematory 4 Donation 5 Other (Specify) tro Funeral Service L Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sis Due to (or as a consequence of): Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that in the cause of the ca Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of)

Physician/ Medical Examiner

Physician/

Medical

10a. State

Director

Funeral

Completed by

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Examiner

Funeral

Director

ral", or items 23a or 28a-f shov Examiner must be notified at

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Completed by Physician/Medical

Be မ

Certificate:

Medical

(Check

only one

29b. Signature and the of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Examiner

been signed by the attending physician and should be detached for use as the burial-transit neral Director: After this certificate has tilled in by the funeral director, page 2 s

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

•	u.				
FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live Birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 🗌 Ectopi	ic pregnancy (specify)		23d. Date of delivery Month Day Year
art II. Other significant conditions	s contributing to death but not re	sulting in the underlyin	g cause given in Part I.	23e. Did tobacco	24b. Were autopsy findings available prior to completion of cause of death?
. Was case referred to medical			26. Place of Death (Che		
examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3	Otto		6 DO Other (Specify) WG SPL 4
7. Manner of Death 1 Natural 5 Pending 2 Accident Investigat		28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	7
3 ☐ Suicide 6 ☐ Could no: 4 ☐ Homicide determine			ory, office	28f. Location (Street a City or Town, Stat	nd Number or Rural Route Number, e)
9a. Certifier 1 Certifying Pl	nysician: To the best of my know	ledge, death occured	at the time, date and place,	and due to the cause(s) a	and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

NOCWED

State Registrar

DHMH 17 Rev 7/2009

24 hours after deat Funeral Director:

To the within 2

Registrar

JACKIE JONES.

CRNP

NOVEMBER

MILDRED WITH

TIMONIUM, MD 21093

2300 DIILANEY VALLEY RD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 00 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Dav Year Rose Marie Wroten 5:55 PM Medical 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death itizens Nursing Home Grace 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🔀 F Days Hours Min. 212-03-1973 92 16777791998 Marÿľand **Director** Yrs. Usual Residence of Decedent of Health and Mental Hygiene. item 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Aberdeen Harford 1 X Yes 2 No <u>Maryland</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21001 471 Roberts Way USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 X No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker At Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Ullrich Mary Wellein permit. Page 1 and 2 should be Department of Health and Ment Important; If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Ruth / Daughter 471 Roberts Way, Aberdeen, MD 21001 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore Gardens of Faith Cem. 11/24/2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signat wood Puneral Service censee Tarring-Cargo Funeral Home, P.A. 333 S. Parke St, Aberdeen, MD 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Luchalion Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 2wks. al nu Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Dav Year been signed by the should be detached 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? s certificate has b lirector, page 2 sh 24a. Was an performed? 2 🗌 No 1 Tes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: မှ 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Mannex of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No Accident
Suicide Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral Completed filled Medical Effectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) D32600 Whan Ms 11/22/10

DHMH 17 Rev 7/2009

State Registrar 1106 Revolution St

Harre De Grace MD 21678

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Milliani Mo

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔈 🕦 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical Month 2010 Nov.19, 1:15 № Robert Lewis Winkler 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore 5. Social Security Number 8. Date of Birth May 12 , 1941 6. Sex If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last hirthday) 9. Birthplace (State or Foreign Days Hours 1 🖵 M 2 🗆 F 228-50-7828 69 VA . Director Usual Residence of Decedent or 28a-f show 10a. State 10h County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Baltimore Yes 2 No MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 617 Springfield Ave. 21212 USA death v 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 A No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) ForkLift Operator Beer Co. $12 \pm h$ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Preston Winkler Eva Stokes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gertrude Winkler (wife) 617 Springfield Ave. Balto, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot Burial 2 Cremation 3 Removal from State Date cemetery, crematory or other place) WoodLawn Cemetery Nov.30,2010 Donation 5 Other (Specify) Balto.Co.MD ature of Funeral Service Licensee Calvin B. Scruggs Funeral Home Preston St. Balto Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ METASTATIC CARCINOMA OF UN KNOWN disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or) **Hospital or Attending Physician:** The law requires that the death certificate be executed 24 hours after death. Cause (Disease or iinjury that initiated events and the burial-trar Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Year 5 Other (specify) Pregnant at time of death 9 Unknown the page 2 should be detached g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has performed? Yes 2 No 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 2 No ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Sp 27. Man of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural injury 5 Pending 1 Tyes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital or within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

DHMH 17 Rev 7/2009

29b. Signature and title of certifier

ICHAEL 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dav Month RoseMary Wiley 3:57 № 201 Medical November 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8110 Bullneck Road Dundalk Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth

(Month, Day, Year)

June 2, 1943 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Days Min. 67 **Director** 213-28-6500 Maryland Usual Residence of Decedent "natural", or items 23a or 28a-f show idical Examiner must be notified at 10a State 10b. County 10c, City, Town or Location Director 10d. Inside City Limits Maryland Baltimore Dundalk 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8110 Bullneck Road 21222 within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 🛛 No If Yes, Give þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the St. Rita Convent Cook 9 yr's Be t. Page 1 and 2 should be filed rtment of Health and Mental Hi rtant: If item 27 is marked oti njury or other traumatic even 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Joseph Howe Sr Florence **Blanche** Burkmaier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17816 Timber Lane Hagerstown, MD 21740 Mrs. Shirley Tate - Daughter Important: If item 2 any injury or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Nov. 18,201D Middle River, MD Holly Hill Signatur Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk 7922 Wise Avenue Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure list only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Physician/ ulmbhary disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter chaerlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day Year signed by the a d be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HEAVE Fal せっていしど 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed d15 EASE ulmonav 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 2 1 No 1 Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending e roce n 24 hours after deau., ne Funeral Director: Af work?
1 Yes 2 No Accident ☐ Acciden☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number Whowly 35102 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sau North Charles Street Ano Ball DON M.D Move 1 DVY 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Stephanie Wast 2010 20 01:34 PM OCTOBER Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death AGNES HOSPITAL SAINT BALTIMORE 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 218-66-0147 1 🗆 M 2 🗹 F Min. Hours Director MARYLAND Usual Residence of Decedent 28a-f show 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 23a or 10e. Street and Numbe 10g. Citizen of What Country? Funeral items , 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 ò þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: "natural" 3 Divorced Completed acl 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) tood SERLACE anager it. Page 1 and 2 should be filed wi rtment of Health and Mental Hygic rtant: If item 27 is marked other njury or other traumatic event, t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ൧ RICE JR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or twict1 20a. Method of Disposit 20b. Place of Disposition (Name of 20c. Location - City or Town, State remation 3 Removal from State 1 Rurial cemetery, crematory or other pla 4 Don on 5 Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirate v arrest. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ BRAINSTEM disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ SEIZURE DISOEDER Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown HYPER LIPIDEMA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nerforme certificate MIERTENSION Yes 2 No 2 **X**No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: မှ 1 Supatient 2 ER/Outpatient 3 DOA Director: After this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending hours after death ☐ Accident 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spēcify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier 1 Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 General phases and the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Centrying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar 29b. Signature and title of certifie

WIT)

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EPHANII

29c. License number

D0070917

900 CATON AVE

29d. Date signed (Month, Day, Year)

OCTUBER 20, 2010

21229

Werthamer, Nurith Baltimore, Maryland 21215-0036 $\#\mathcal{A}\mathcal{A}$ Division of Vital Records, P.O. Box 68760

		Please	Type or Print in I	Black Ir	ndelible In	k. Ensure	All Copie	es Are	Legible	
		1 - State Amend Items	State of Marylands 29c,d per dr				•		_	36804
Physic Me	cian/ dical	Decedent's Name (First, Middle, Last) NURITH	WERTHAM	ER			2. Date of D Month	eath Da	y 201	3. Time of Death 7:45 A M
Exan		4a. Facility Name (if not institution, give s Franklin Square Ho 5. Social Security Number 16. Sex	spital cente		Rosedi			В	County of De	ore
Funer Directo		, , , , , , , , , , , , , , , , , , , ,	7. Age (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B		9. B C	irthplace (State or Foreign ountry) ROMANIA
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	Funeral Director	10a. State 10b. County MD BALTIM 10e. Street and Number 3414 ASSOCIATED 1 11. Marital Status	ORE ON WAY, #418		MILLS 10f. Zip Code 2111	lispanic Origin? (Sp	pecify Yes or No		tizen of What C USA 14. Race - Am	
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within 72 ho giene. her than "nat t, the Medica"	e Completed	15. Decedent's Edu (Specify only highest grad Elementary/Seconday (0-12) 1 2	ucation e completed) College (1-4 or 5+)	(Give k life. DC	ent's Usual Occup kind of work done of NOT use retired) NICURIST	during most of wor	king		ind of Business	•
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and 2 shou Health and em 27 is n		19a. Informant's Name/Relationship (Typ RONY WERTHAMER/SO 20a. Method of Disposition	ON	7 St	UTHERLANI	O COURT,	PIKESVI	LLE,	MD 21	208
iit. Page 1 artment of 1 artant: If its	.51	1 M Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Funeral Services 22. Signature of Funeral Services 23. Signature of Funeral Services	Removal from State ARL AMUN	metery crem INGTON IO_CON(111/2	Date 22/2010	В	ALTIMOF	RE, MD
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cate be executed Medica Examine physician and sthe burial-transit	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, from Lean to the cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	Due to (or as a consequence of the to (or as a consequence of	ence of): Liver						Interval Between Onset and Death
ath certifi attending for use as	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Bc. If yes, outcome of pregnan 1 Live Birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnand Other (specify)	Sy .			23d. Date of de Month	elivery Day Year
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uttending Physical death.	Certificate: T	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be		28b. Time of injury	28c. Injury work	/ at	28d. Describe			city)
To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completed filled in by the fi		4 - Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)				City or To	wn, State)		ural Route Number,
o the Hos vithin 24 ho o the Fund completed	Medical	(Check 2 ☐ Medical Examine	rian: To the best of my knowle r: On the basis of examination Practioner: To the best of my	and/or investi	gation, in my opinio	on, death occurred a e time, date and pla	at the time, date oce, and due to the	and place, ne cause(s	, and due to the	cause(s) and manner stated s stated,
F \$ F 0		Danuel g	human MD) 23a) (Time P	RESO	บวงช)94		mber 3	
0	ate	DanielShinners	5. MD 9000 Frai	nKlin	Caurre D	rive Ba	ltimor	е м	p 21;	237
Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	park						

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November Physician/ LORENA WITHROW J. 2010° а м 12:54 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 507 Luther Road Glen Burnie Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Ye August 4, 1 M 2 X F Months Days Hours West Virginia Director 212-34-0375 Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Glen Burnie 1 Yes 2 X No 10e. Street and Number 10f. Zip Code ō 10g, Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be with 1 Funeral 507 Luther Road 21061 U.S.A. 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11 Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. þ 1 Never Married 2 Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White 3 K Widowed 4 Divorced Completed 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than any injury or other traumastra. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Hame 10 n Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Thomas Osborne Neff Monnie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hubert H. Withrow Jr. (Son) 810 220th Street, Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Glen Haven Memorial Park Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 21. Signature of Fundal a rvice License 3204 Mountain Road, Pasadena, Maryland 21122 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Interval Between Onset and Death rediate Cause (Final Fnysician/ ementia) disease or condition years Medical resulting in death) Due to (or as a consequence of) Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) -transit Exami that initiated events Due to (or as a consequence of): resulting in death) Last burial-1 attending physician for use as the burial Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Year Yes 2 No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown To the Hospital or Attending Physician: The law require within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should be . Were autopsy findings available prior to completion of cause of death? 24a, Was an autoosy perform 2 🕅 No Yes 2 X No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 🕅 No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🙇 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) R118354 11/20/2010

Registrar

DHMH 17 Rev 7/2009

State

Oak Point

ct Pasadera, MD 21122

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

7900

32. Registrar's Signature

Schuler

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryla		artment of H tificate of D		nentai Hy	giene Reg. No.	010	36806
	Physicia	n/	1. Decedent's Name (First, Middle, Las	*				2. Date of De	eath	-Year	3. Time of Death
	Medic	al	ADELE 4a. Facility Name (if not institution, give		RBERG	L		NOVEMI	BER ^{Day} 20,		7:31 AM
- Andrews	Examin	er	GILCHRIST HOSPIC	·		4b. City, Town, or I	Location of Death			nty of Death LTIMOR	Œ
	Funeral		Social Security Number 6. Security Number	7. Age (In yrs.	last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Bir	th	9. Birthp	lace (State or Foreign
	Director		213-20-5432 Usual Residence of Decedent	□ M 2 X F 8	5 Yrs.	Worth's Days	riours with	10705	71925	Count	MD
	and show l at	or	10a. State 10b. County	10c. Ci	ity, Town or Lo	cation	-		-	10	0d. Inside City Limits
	Maryl. 28a-f otifiec	irect	MD BALTIM	ORE B	ALTIMOF	RE					1 ☐ Yes 2 🔀 No
	h the	al D	10e. Street and Number			10f. Zip Code			10g. Citizen o		try?
	ath wii	Funeral Director	7919 LONG MEADOW	ROAD 12. Was Decedent Ever in U.	S 13 V	21208 Vas Decedent of His		ocify Ves or No-	USA		an Indian
9	er dez or ite miner	by F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 👿 No	H	Yes, specify Cuban	, Mexican, Puerto	Rican, etc.)		ace - America lack, White, e	
200	urs af tural", al Exa	ted	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates.	1	☐ Yes 2 🔀 No	Specify:		Speci	ify: WH	ITE
5	72 ho n "nai Aedici	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Give I	lent's Usual Occupat kind of work done du D NOT use retired)	tion Inin <i>g m</i> ost of worki	ing	16b. Kind of	Business Ind	lustry
212	s filed within 72 hours after death with the Maryland tal Hygiene. cd other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		Elementary/Seconday (0-12)	College (1-4 or 5+)		LTOR			REAL	ESTAT	E
Maryland 21215-0036		To Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,	Maiden Surna		
2	should be fi n and Mental 7 is marked raumatic ev	_	OSCAR 19a. Informant's Name/Relationship (Ty	ZACANSKY	T		MOLLIE		7		VINSKY
	12 shou alth and 27 is m r traum	li 6	ALAN ZUKERBERG/S	,	11	g Address (Street ar LONG MEA					208
e,	ge 1 and 2 should be to flealth and Mer if item 27 is marke or other traumatic		20a. Method of Disposition	20b.	Place of Dispos	sition (Name of natory or other place		Date	20c. Locatio		
Baltimore,	Page tment o tant: If jury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)		IAI CONG.		2/2010	OWIN	GS MIL	LS, MD
Ball	permit. Pag Department Important: any injury o		21. Signature of Funeral Service License			Name and Address 8900 REIST					
			23a. Part 1. Enter the disease, or comp	lications that caused the dea						LLE, F	Approximate
Į	Physician/	S 3	shock, or heart failure. List only or Immediate Cause (Final disease or condition		lmon	ale					Interval Between Onset and Death
	≰ Medical Examiner		resulting in death)	a. Due to (or as a consequence SUNENE Consequence)	juence of):		4	1 .			
		Je.	Sequentially list conditions, if any, leading to immediate	b. SLVENE C	uence of):	cobstru	nvelu	y disi	ease		y-ears
	uted d ansit	amir	cause. Enter Underlying Cause (Disease or iinjury that initiated events		,					1	10
	e exectian an	edical Examiner	resulting in death) Last	Due to (or as a conseq	juence of):						
09/	To the Hospital or Attending Physician: The law requires that the death certificate be executed within E4 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	edic		d							
200	certifi anding use as	M/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live Birth 2 ☐ Fet	ancy] [23d. [Date of delive	ry
X POX	death he atte ed for	Physician/M	in the past 12 months? 1 ☐ Yes 2 【 No 9 ☐ Unknown	4 Pregnant at time of Unknown		Other (specify)			١ ١	Month	Day Year
7. Ö.	at the ed by the detach		Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	nderlying cause give	n in Part I.	23e. Did t	obacco use co	ntribute to the	e cause of death?
S,	uires the signer and be a	d be	ceremovasular	uctives, rec	went	premo	ma	1 🗆	Yes 2 No	3 🗆 Prob	ably 4 🗆 Unknown
Š 5	iw required is been 2 shou	plet	cere movasular	accident	-			24a. Was auto		. Were autop	sy findings available
Vital Records,	The Is cate ha	Completed by						perfo	ormed? 2 No	death?	
<u>ra</u>	sician: certific rector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:		Othor	ce of Death (Check				4-0
<u> </u>	g Physer this eral di	e: To	27. Manner of Death	1 Inpatient 2 28a. Date of injury	28b. Time of	t 3 □ DOA 28c. Injury a	4 ☐ Nursing Ho at		dence 6 100		HOSpith
0	eath. or: Aft. he fun	ficat	1 X Natural 5 Pending 2 Accident Investigation		injury	M 1 🗆 Y	es 2 □ No				
DIVISION OF	or Att after d Direct in by 1	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At his building, etc. (Specif		et, factory, office		28f. Location (\$ City or Tov	Street and Num vn, State)	ber or Rural	Route Number,
ב	ospital hours ineral d filled	Medical	29a. Certifier 1 Certifying Phys	ician: To the best of my know	/ledge, death o	ccured at the time, o	date and place, an	d due to the ca	use(s) and mar	ner as stated	i.
	the Hi hin 24 the Fu	Med	only one) 3 Certifying Nurs	ner: On the basis of examination of me Practioner: To the best of m	ıy knowledge, d	eath occurred at the	time, date and plac	e, and due to th	e cause(s) and I	manner as sta	ted.
_	o vit		29b. Signature and title of certifier	2 00(x)		29c. License r	number		29d. Date sign	ned (Month, E	ay, Year)
			30. Name and address of person who co	ompleted cause of death (Iten	n 23a) (Type. Pi	rint)	0477		11/20	110	
			laura Patel,	6701 N Ch	alles	St Suite	4105	Bal	timor	e, M	120215
	Stat Registra	e r	31. Date filed (203), 2010(1)	completed cause of death (Iten	CLACE					1	

State Registrar (Check only one)

29b. Signature and title of certified

31. Date filed (Month, Day,

1+J13011110

DHMH 17 Rev 1/2001

NATI

and manner stated.

22

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MA

2010 ▶

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

DOUL7565

L2 U2/2

29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

			Please	Type or Pri						•		gible.	
		For State		State of M	arylan	•				al Hyg	iene		
		Registrar 1. Decedent's Nam	e (First, Middle, La	st)		Cer	tificate of	Death		ate of Deat	leg. No	110	3. Time of Death
Physicia Medic	al	MAR	JORIE		BUT	LEI	۷		7	onth	3 ^{Day}	10	2045 M
Examin	er		not institution, give d Estates	e street and number)			4b. City, Town, o	r Location	n of Death			nty of Death	orge's
Funeral		5. Social Security N	umber 6. 5			st birthday)	If Under 1 Year Months Days	If Und	er 24 Hrs. 8. Da	ate of Birth		9. Birth	place (State or Foreign
Director		358-07-0 Usual Residence of	311		92	Yrs.			Бер	t. 18	3 ^{Year)} 1918	3 Illi	nois
aryland a-f sho fied at	ctor	10a. State	10b. County Prince (Corree le	10c. City Bow	, Town or Lo	cation						10d. Inside City Limits 1 Yes 2 □ No
the Ma or 28% oe notii	Funeral Director	10e. Street and Nur		ecige s	DOW	16	10f. Zip Code			1	10g. Citizen o	f What Cou	
th with ns 23a must b	inera		ealth Cer				2071				USA		
er dea or ite miner	by Fu	 Marital Status Never Marr 	ied 2 🗆 Married	12. Was Decedent E Armed Forces? 1 \(\sum \) Yes 2 \(\begin{array}{c}\begin{array}{c}\delta\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	ver in U.S No		Was Decedent of F f Yes, specify Cub			es or No- etc.)	В	ace - Americack, White,	etc.
ours aff	ed	3 🔀 Widowed		If Yes, Give Year or Dates.			Yes 2X No		fy:		Speci	_{fy:} Whi	.te
n 72 ho e. ian "na Medic	Completed	(Spe	15. Decedent's E ecify only highest gr		:+1	(Give I	lent's Usual Occup kind of work done O NOT use retired)	durina ma	st of working		16b. Kind of	Business In	dustry
d withi tygiene ther th nt, the	ou l	12			.,	Homen	aker	<u> </u>			Own Ho		
l be file fental F rked o tic eve	일	17. Father's Name (Patri	rirst, Middle, Last) ck Halley	7				1	ther's Name <i>(First,</i> ie Marie			ne)	
should and N		19a. Informant's Na				1	g Address (Street						
1 and 2 f Health item 2 other t		Marcy Fo		Daughter	20b. PI	ace of Dispo	6 Leland sition (Name of		, Chev		se, MI 20c. Location		
Page ment or ant: If ury or			☐ Cremation 3 ☐ 5 ☐ Other (Speci	Removal from State	Ce	emetery, cren ington	natory or other place Nat'l C	em.	12/6/20	10	Arlino	gton,	
permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signatura of Ful	neral Service Licen	see			Name and Addre				ral Ho .e, MD	ome 2071	E
		23a. Prt 1. Enter t	disease, or com	plications that caused	the death							2071	Approximate
Physician/		Immediate Cause (disease or condition	Final	one cause on each line	Pun	enti	a						Interval Between Onset and Death
Medical Examiner		resulting in death)	ſ	Due to s a	a consequ	ence of):							
	iner	Sequentially list co If any, leading to in cause. Enter Under	nmediate	b. Due to (or as a	consequ	ence of):							
e executed cian and ourial-transit	Examiner	Cause (Disease or that initiated events resulting in death) I	iinjury s	c. Due to (or as a	conseque	ence of):						-	
Attending Physician: The law requires that the death certificate be executed ar death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transi	dicat			d									
ertificat ding ph	/Mec	IF FEMALE:		23c. If yes, outcome of	of pregnar	ngv							
death certi e attendin d for use a	Physician/Medic	23b. Was decedent in the past 12 r 1 Yes 2 S	months?	1 Live Birth 4 Pregnant at	2 🗌 Fetal	death 3	Ectopic pregnand Other (specify)	СУ				ate of delivionth	ery Day Year
ires that the dea signed by the a d be detached f		9 Unknown Part II. Other signif		9 ∐ Unknown ontributing to death bu	ut not resu	Ilting in the u	nderlying cause gi	ven in Par	rt I.	3e Did tob	acco use cor	atribute to th	ne cause of death?
uires th n signe ald be c	ا ۾												bably 4 nknown
law require has been si je 2 should b	Completed								24	4a. Was an		prior to co	psy findings available mpletion of cause of
ician: The la certificate ha rector, page		25. Was case referre	ad to modical						1	perform	ned?	death? 1 Yes	2 🗆 No
nysician: nis certific director,	To Be	examiner?		Hospital:	ent 2 🗆 E	R/Outpatien	Oth	or.	eath (Check only o		nce 6 🚺 Ot	her (Specify	ALF
ding Pl h. After th funeral		27. Manner of Death Natural	5 Pending	28a. Date of injur (Month, Day,	y ; Year)	28b. Time of injury	28c. Injur work M 1 🗆			escribe hov	w injury occu	rred	
er deat rector: by the	Certificate:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	Investigation 6 Could not be determined			ne, farm, stre		res 2	28f. Lo			ber or Rural	Route Number,
pital or ours aft eral Dir filled in		00a Cadifia 4	W3-44-5-04	6						ty or Town,			
To the Hospital or Attending Physic within 24 hours after death. To the Funeral Director: After this or completed filled in by the funeral dire	Medical	(Check 2	Medical Exam	sician: To the best of r iner: On the basis of ex se Practioner: To the b	amination	and/or investi	igation, in my opinio	on, death o	occurred at the tim	e, date and	d place, and d	ue to the car	use(s) and manner stated.
vith to the		29b. Signature and	title of certifier	Visi	201 V		29c. License	number	-8	29	od. Date sign	ed (Month,)	Day, Year)
2		30 Name and addre	ess of person who	completed cause of de	eath (Item :	23a) (Type, Pi	rint)	Y 8 =	<u> </u>	/	11/8	2/1	0- 144
ω		SUSA 31. Date filed (Monti	n, Day, Year)	KKIEGO 32. Registra	ell,	MD	445	1)efe	ense t	tell	Hell	rapol	is, my
State Registra	-	, , , , , , , , , , , , , , , , , , , ,	NOV 032	2010 Jenes	W.	A. A	back					218	40/
MIL 47 D 7/00/	20			-									

36809

			State	of Maryland	•	tificate of L		, ,		
			Registrar 1. Decedent's Name (First, Middle, Last)			imouto or i	- Journ	2. Date of Dea		3. Time of Death
	Physicia Medic		Cynthia D. Brown					Octobe	er 26 201	0 1449 ^M
	Examin	er	4a. Facility Name (If not institution, give street and nur Anne Arundel Medical			_	Location of Death		4c. County of Dea	
	Funeral		Social Security Number	7. Age (In yrs. last b	birthday)		If Under 24 Hrs.	8. Date of Birtl	Anne A	rthplace (State or Foreign
	Director		214-66-3799 ^{1 □ M 2} X F	55	Yrs.	Months Days	Hours Min.	une ^{th,} i	9 ^{Year} 1955 Ma	Tyland
	nd how at	٦	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Loc	ation				10d. Inside City Limits
	larylar 3a-f sl iified	Director	Maryland Anne Arundel	1 2						1 ☐ Yes 2 X No
	the N		10e. Street and Number			10f. Zip Code		T	10g. Citizen of What C	ountry?
	ns 23. must l	Funeral	777 Macsherry Dr.			210			USA	
_	r deat or iten niner i		Armed Fo		13. W	las Decedent of H Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
25	rs afte ral", c Exan	ed by	1 ☐ Never Married 2 🔏 Married 1 ☐ Yes 3 ☐ Widowed 4 ☐ Divorced If Yes, Giv Year or D	e ates.	1	☐ Yes 2X No	Specify:		Specify: B	lack
9500-61212	2 hou "natu edical	plet	15. Decedent's Education (Specify only highest grade completed	16	(Give k	ent's Usual Occup	ation during most of work	ing	16b. Kind of Business	Industry
7	ithin 7 ene. r than the Mo	Completed	Elementary/Seconday (0-12) College (1 12th 1yr) NOT use retired) ima IIn d	erwrite:	r	MAIF	
ב פ	iled w Il Hygi I other vent, i	Be	17. Father's Name (First, Middle, Last)		Ста	IIIS OHG			Maiden Surname)	
yland	ld be l Ments arked atic e	욘	Kenneth C. Jackson				Ethel :	D. Brow	vn	
Mar	shou hand 7 is m traum		19a. Informant's Name/Relationship (Type, Print)			_			City or Town, State, Z	
e)	and and the Healt tem 2		Leroy R. Brown Jr(Hu 20a. Method of Disposition	20b. Place	of Dispos	Macsher	1	Date	d, Md. 21	
Ē	Page ' nent of int: If iny or		1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)			atory or other place remator		3-10	Baltimor	
baitimoi	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Sas or 28a-f show monthant. It is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee		P61	Name RAGG	e of LicinSon:		ary, P.A	•
_			Larry B. Reese M.						s, Md. 21	1
	Na /		23a. Part 1. Enter the disease, or complications that a shock, or heart failure. List only one cause on example the cause (Final	ch line.	o not ente		g, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
	Physician/ Medical		disease or condition	or as a consequenc	ce of):	re of	emory !	Cay L		
	Examiner	٠,	Sequentially list conditions, b					V		
-	sit sit	edical Examiner	if any, leading to immediate Due to cause. Enter Underlying Cause (Disease or linjury	or as a consequenc	e of):					
	xecute n and al-tran	Exa	that initiated events C.	or as a consequenc	e of):					
2	ath certificate be executed attending physician and for use as the burial-transit	lical	d							
00			IF FEMALE:	name of programmy						
XOO :	attence for us	cian	in the past 12 most be?	come of pregnancy Birth 2 Fetal dea nant at time of death		Ectopic pregnand Other (specify)	ey .		23d. Date of de Month	elivery Day Year
	the de by the ached	Physician/N	9 Unknown 9 Unki	iown						
	s that gned I be det		Part II. Other significant conditions contributing to d	eath but not resultin	1	nderlying cause giv	en in Part I.		bacco use contribute to	
ecords,	equire seen si hould	Completed by	1 - 500		حد ا					Probably 4 Unknown
ည မ	e lawı e has b ge 2 s	mpl	by pertension					24a. Was a autop perfor	sy prior to death?	
ב ק	an: Th tificate or, pa	Be Co	25. Was case referred to medical			26. Pl	ace of Death (Chec		2- No 1 ☐ Ye	s 2 No
	rysicia nis cer direct	To B	examiner? 1 ☐ Yes 2 ☑ No Hospital:	Inpatient 2 ER/	'Outpatient	Oth	or:		ence 6 Other (Spec	cify)
5	ling Pl		27. Manner of Death 1 ✓ Natural 5 ☐ Pending 28a. Date (Mon	of injury 28b h, Day, Year)	o. Time of injury	28c. Injun work	?	28d. Describe ho	ow injury occurred	
VISION	Attend death ctor: / y the 1	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place	of Injury - At home,	farm, stre		Yes 2 No	28f. Location (Si	treet and Number or Ru	ural Route Number.
	tal or / s after al Dire ed in b			ng, etc. (Specify)	,			City or Towi		,
	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use a	Medical	29a. Certifier 1 Certifying Physician: To the base (Check 2 Medical Examiner: On the base)	est of my knowledge is of examination and	e, death o	ccured at the time	, date and place, ar on, death occurred a	nd due to the cau t the time, date ar	se(s) and manner as st nd place, and due to the	ated. cause(s) and manner stated.
	o the	Me	only one) 3 Certifying Nurse Practioner. 29b. Signature and title of certifier	To the best of my kno	owledge, de	eath occurred at the			cause(s) and manner as	
	- 5 F O		1			Doa	35879-	7	T . /	2010
	360		30. Name and address of person who completed caus	e of death (Item 23a	a) (Type, Pr	int)	W-7-	0 -	P A	XI MID
			31. Date filed (Month, Day, Year) 32/B	egistrar's Signature	rest	vund el	FROKO	1 Com	V Ama	~115 110)
	Stat	e	NIOV 0.3 2010 1 36	giotiai o digriature	4.	11 1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 1:11 Joan Burleson Blum November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Park Montgomery Takoma Social Security Number 6. Sex Age (In yrs. last birthday) Year If Under 24 Hrs 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Funeral Days Min. Year) 1 □ M 2🗶 F Months Hours Washington 71 1939 **Director** 14 226-46-7799 חכ Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 Tes 2 No Virginia 10e. Street and Number Lovettsville Loudoun 10f, Zip Code 10g, Citizen of What Country? Funeral 11910 Purcell \cdot S Road 20180 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Secretary/Treasurer 12 Construction Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Julia MaGruder Jones Ernest Burleson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11910 Purcell Rd., Lovettsville, VA Bernie Blum - Husband Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date 10 cemetery, crematory or other place) Nov. X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lovettsville Union 2010 Lovettsville, Virgini 21. Signature of Funeral Service Licenses 158 Catoctin Crl Loudoun Funeral Chapels Leesburg, VA 20175 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Aspiration Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner YEARS End sta Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a sonsequence of Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 🕱 No
9 ☐ Unknown Month Day Year 4 Pregnant 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertruphic Obstantitude Candra myspathy 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Concer - status post left lobe its my 24b. Were autopsy findings available prior to completion of cause of death? has autopsy Gastro intesting! Yes 2 X No 1 Yes 2 No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 3 \subscriber Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Defitying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MD 22846 November 7, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maple Arenne, Takuma Park, MD 209/2
RUBERT DIBIANCO, MD; 7901 Maple Arenne, Takuma Park, MD 209/2 32. Registrar's Signature 31. Date filed (Month, Day, Year) parke State NOV MARKER

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ROBERT ORA BURWELL November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Center Medica Sex 1 XM 2 □ F 8. Date of Birth 9. Birthplace (State or Foreign Country) Michigan last birthday) If Under 1 Year **Funeral** Months Days Hours 364-09-6518 93 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 Yes 2 No MD. Baltimore Hydes 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13211 Long Green Pike 21182 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Bace - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White II 3 X Widowed 4 Divorced Completed ed other than "nature event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Automobile Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked ဂ Burwell Benjamin Lottie Fraser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health Important: If item 27 13211 Long Green Pike Carol J. Gupta (Daughter MD. 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Nov. 16, 20c. Location - City or Town, State injury or 4 Donation 5 Other (Specify) Carroll 2010 Cremation Hampstead, Maryland any inj once, 22. Name and Address of Facility 21. Signature E.G. Kurtz & Son Funeral Home. P.A Jarrettsville. Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of) disease or condition resulting in death) Tract Medical **Examiner** EVEVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Dualto for ex a noneriquence o attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Fctopic pregnancy in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 5 Other (specify) ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be det Completed by lostridium Difficule 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? 1 ☐ Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate:

Division of Vital Records, P.O. Box 68760 After this certificate funeral director, within 24 hours after death.

To the Funeral Director: A completed filled in by the fu

1XXNatural 5 \square Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined

State Registrar

Medical

29a. Certifier

(Check only one

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ve 's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

11.14.10

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Bateman 15,2010 November **Physician** Linda /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore City The Johns Hopkins Hospital 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) PENNSYLVANIA **Funeral** 1 □ M 2 🗓 F 2/6/1948 62 191-38-4413 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h. County 10a. State 28a-f show 1 Yes 2/XNo permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryli. Department of Health and Mental Hygiene. Insportant: If item 27 is marked other than "natural", or Items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at once. Director MARTINSBURG BERKELEY WV 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number USA 25404 17 HIALEAH PLACE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc WHITE 1 Never Married 2 Married Yes 1 ∏ Yes 2 No Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TEACHER Completed 15. Decedent's Education (Specify only highest grade completed) **EDUCATION** College (1-4 or 5+) Elementary/Secondary (0-12) 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be IRENE SMITH MARTIN TAYLOR DUMBAULD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 17 HIALEAH PLACE, MARTINSBURG, WV 25404 DAVID CHARLES BATEMAN/SPOUSE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State SMITHSBURG, MD SMITHSBURG CREMATORY 4 Donation 5 Other (Specify) BROWN FUNERAL HOME, PO BOX 821, 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Robut 327 W. KING ST., MARTINSBURG, WV 25402 reids Approximate Intervat Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final tailure Respiratory pulmonery **Physician** disease or condition resulting in death) Due to or as a consequence of) /Medical Examiner Circhosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine nonalcoholic Steatohepatitis burial-transit law requires that the death certificate be executed and Due to (or as a consequence of) Physician/Medical the use as IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Year 2 - Fetal death 3 Ectopic pregnancy Month Live birth Day in the past 12 months? completely filled in by the funeral director, page 2 should be detached for Pregnant at time of death 5 Other (specify) 2 N/No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed) Yes 2 No 1 Nes Yes 26. Place of Death (Check only one) 25. Was case referred to medical or Attending Physician: Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 3 DOA 1 Minpatient 2 ER/Outpatient 1 ☐ Yes 2 No မ 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 Suicide 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (check only

Division of Vital Records, P.O. Box 68760, 24 hours a the Hospital Within 2 To the F

> Ahned Haitham NOV 2 3 20 032. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

0

one)

29b. Signature and title of certifier

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

November 15, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCTOBER 10: 55 AM Lyle Cathcart Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death **Funeral** 8. Date of Birth 1 ▼ M 2 □ F Months Min. (Month, Da) 96 Hours 214-03-1343 Director 09.1914 Maryland Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director Anne Arundel Severna Park 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 36 Holly Road 21146 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ğ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 ☒ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Artist Commercial Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence Creston Cathcart Carrie Edna Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9792 Martingham Circle Unit #1 St. Michaels, MD Creston L. Cathcart / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State November 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Broad Creek United Bozman, MD 2010 Methodist Church Cemetery Barranco & Sons, P.A. Severna Park Funeral Home 21. Signature of Funeral Service Licensee 495 Ritchie Hwy Severna MD 21146 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the alsease, Approximate Interval Between Onset and Death shock, or heart ailure. List only one cause on each line Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the bunal-transit that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy Pregnant at time of death Month Day Year 5 Other (specify) ned by the a P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, the Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, I 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Unpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Norse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of pertifier 29d. Date signed (Month, Day, Year) 11-01-10 19 son who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 **Physician** Nov 13. 6:25 AMM Carnev Levada /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany Golden Living Center Cumberland | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sep 11, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1□ M 2□,F MD 219-14-6558 Director 87 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 28a-f show permit. Pages I and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, Item Medical Exam. In a coust by notified as Allegany MD 1 □Yes 2 □ No Cumberland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21502 USA 512 Winifred Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give 2 **X**Vo 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐Xio ģ Specify 3 XWidowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Celanese Corp laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary E. (Anderson) Humbertson Azariah Humbertson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print)
Mary Catherine Kesner MD 21502 daughter 120 Massachusetts Ave. Cumberland 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Memorial Park 11/17/2010 MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 21. Six ature of Funeral Service Licensee 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SID recentivil Law weller **Physician** AD) disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner bludin Fow cuelk Sequentially list conditions Due to for as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit and law requires that the death certificate be execu Due to (or as a consequence of) the attending physician hed for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 K No 9 ☐ Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown cate has been si page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 1 □ Yes 2) No 1 ☐ Yes 2 No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certificar completely filled in by the funeral director, p. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No a ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar HUMA SHAKI 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

32. Registrar's Signature

625 KENTAVE. STE. 204 CLIMBERLAND, MD 21502

316

State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 40 736 M Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arunde1 . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Dec 12 Months Hours Year 1946 Maryland 218-46-5436 63 Director Usual Residence of Decedent or 28a-f shov notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Glen Burnie Maryland Anne Arundel 1 ☐ Yes 2X No 10e. Street and Number 10f Zin Code ō 10a. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 7900 Benesch Circle Apt 827 21060 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. 1 Never Married 2X Married þ Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes Give Specify: 3 ☐ Widowed 4 ☐ Divorced **Black** Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Anne Arundel Co. permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12th Ò Custodian Board of Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samuel Dorsey Sr Rosie Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21060Larry N. Dobson Sr(Husband 7900 Benesch Circle Apt 827 Glen Burnie, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Metro Crematory 11-1-10 Baltimore, Md. 4 Donation 5 Other (Specify) Winname Recesse of &cilisons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between or set and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or linjury that initiated events Due to for as a consequence on Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Year Pregnant at time of death the detached 9 Unknown Unknown is been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy autopsy performed? After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending 24 hours after death. Funeral Director: A Accident Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one who completed cause of death (Item 23a) (Type, Print) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Nov 13, 2010 **Physician** 2:05 PM Dolly Mary /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Golden Living Center Allegany Cumberland 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Yea May 25, Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Year) 1 □ M 2 □ F Months Days Hours Min. MD Director 215-16-4469 89 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Canonic 2.

I and Mental Hygiene.

Is marked other than "natural", or items 23a or 28a-f show
is marked other than "natural", or items 23a or 28a-f show
is marke event, the Medical Evanther must be notified at 10a. State Allegany MD Cumberland 1 □ ¥es 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 512 Winifred Road 21502 USA by Funeral be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 □ Yes 2 □ Xo Specify. Specify. 3 □ KWidowed 4 □ Divorced white Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 is marked other any injury or other traumast 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Humbertson Annie (Seib) Humbertson 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) r 12500 Murleys Branch Rd. NE Flintstone MD 19a, Informant's Name/Relationship (Type. Print) Joyce Shipley MD 21530 Daughter Flintstone 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/18/2010 Glendale Cemetery **Flintstone** MD 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 23a. Part J. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Beare Covona **Physician** YYS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 C Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ned by the a ☐Yes 2☐No Ö 9 Unknown 9 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 sign 1 be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No 1 ☐ Yes. 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred After 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Àccident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated

Registrar

29b. Signature and title of

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GIUPTAM.D.

3

DHMH 17 Rev 1/2001

29c. License number

625 KENT AVENUE CUMBERLAND, MD 21502

1000 33 280

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Octob er Richard T. Gibson 4:35) DM 20 10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death nyn mne Baltimore Washington Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day July 29 Social Security Number 9. Birthplace (State or Foreign Country) New York 7. Age (In vrs. last birthday) **Funeral** 1 **X**M 2 □ F .1943 Director 115-32-1416 Usual Residence of Decedent per nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Dey artment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Clark 1 Tyes 2 No Henderson 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1027 Tabor Hill Ave 89074 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Completed by Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates. 1970 -90 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Army Retired Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ V. Miller Wendell Leap Martha 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Judith M. Gibson /Spouse</u> 1027 Tabor Hill Ave Henderson, NV 89074 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 D Burial 2 Cremation 3 Removal from State 5 Q Other (Specify) 4 Donation Metro-Crematory 11-1-10 Baltimore, MD. 22. Name and Address of Facility 21. Signature of Funeral S wice Licenses Beall Funeral Home <u>6512 NW Crain Hwv.</u> Bowie.MD 20715 Part 1. Enter the disease, or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease, or Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year signed by the Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death. Funeral Director: After this certificate has autopsy performed 2 No 2 📉 funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ျှ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural √atural ☐ Accident ☐ Suicid 5 \square Pending 1 Tes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier rtifying Physician; To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature d title of certifi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, State Registrar

Gibbon

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Eva Esther Garman 0:49 A M 0ct Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 6. Sex 8. Date of Birth Funeral (Month, Day, Yea Mar.9,192 1 M 2 TF Director 486-24-5292 86 Missõuri Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No Maryland Anne Arundel Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 161 Edge Way 21012 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔽 No Specify: "natural", 3 Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturaly injury or other traumatic event, the Medical! 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Visiting Nurse Nursing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Stephen Gray S. Maples 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Allen Garman / Husband 161 Edge Way, Arnold, MD 21012 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 10/27/10 Brentwood, Maryland 21. Signature of Junera 22. Name and Address of Facility 147 Duke of Gloucester St. John M. Taylor Funeral Home, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown g Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has lirector, page 2 s autopsy 2 2 No 1 Yes ☐ Yes To the Hospital or Attending Physician: director, Be 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) examiner? Other: 2 - No ျ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral or 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🗮 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 🗖 Centifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 6964 and address of person who completed cause of death (Item 23a) (Type, Print) MD ARNOLD Ritc JAMES CHACONAS 1509 2. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ oodw1 Dovember 25 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cecil E1kton 274 Hollingsworth Manor 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Days Year 963 1 🕅 M 2 🗆 F Months Hours Min Maryland Yrs June 212-80-7525 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If then Z7 is marked other than "nature" any injury or other traumatic events. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 X Yes 2 □ No Maryland Ceci1 E1kton 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? by Funeral United States 21921 274 Hollingsworth Manor 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Yes Yes Yes, Give 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 N Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Carpentry Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lorraine Rhoades Billy Disway Goodwin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 520 Blue Ball Road, Elkton, MD 21921 Robert Shull/Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State November 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) A. Ferris & Co., Inc. 112. 2010 West Chester. 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ - wer iencer disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events are utilitiated events.) Examiner Due to (or as a managemente of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No 9 Unknown eral Director: After this certificate has been signed by the filled in by the funeral director, page 2 should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed 2 🗌 No ☐ Yes 2 ☑ N 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation after death Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Checl Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only o 29b. Signature and title of 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Bay, Year)

NOV

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Name and address of person who completed cause of death (Item 23a) (Type, Print)

283

11-13-10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NOV" 15, 2010 **Physician** 9:20P JAMES DONALD HARDESTY /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner PRINCE GEORGES FORT WASHINGTON FORT WASHINGTON HOSPITAL If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9 (Month, Day, Year) 9 - 18 - 1953 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months WASHY, D.C. 220-62-6518 **™** M 2□ F 57 Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lijury or other traumatic event, the Medical Examiner must hourself the source. 10a. State 10b. County 10c. City, Town or Location 10d. Inside Cify Limits WALDORF MD. CHARLES 1 ☐Yes 2 No Director 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 2201 WESTWOOD DRIVE 20601 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE þ 3 ☐ Widowed 4 🂢 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PIPE FITTER U.S.GOVT. 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GERTRUDE JUANITA LANHAM FRANK EDWARD HARDESTY, SR. 2 19a. Informant's Name/Relationship (Type. Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

ASHLEY M. HARDESTY-DAUGHTER 2201 WESTWOOD DR. WALDORF, MD. 20601 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition 1 Burial 2 MCremation 3 Removal from Starte TROPOLITAN CREMATORY 11-17-10 ALEX., VA. 4 ☐ Donation 5 ☐ Other (Specify) M00479 Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 21. Signature of Funeral Service Licensee LA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) PLUD CM CINTING INCE **Physician** 0 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 1 Natural 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 124 hours after death.

12 Funeral Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific (3a) (Type, Print) 30. Name and address of person who completed cause of death 11711 Livingston Rd Amir Minza -31. Date filed (Month, Day, Year) State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of	Maryland		artmen				lental Hyg	iene	3	6821
I	Physici	an	1. Decedent's Name (First, Middle, Las	it)							Date of Deat Month		ar 3.	Time of Death
	/Medi			ELSIE M	ARIE HA	YES	,					12/2010		3:28 P M
	Examir	ner	4a. Facility Name (If not institution, give				4b. City,		Location of			4c. County of I	Death	
			DORCHESTER G 5. Social Security Number 6. S			as brings at a . 1	If Under		CAMB.				RCHE	
	Funeral Director		,	M 2 ⊠ F	Age (In yrs. las	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, 3/13/	9. 1931	Country) MAF	(State or Foreign
	yland 10w		10a. State 10b. County		10c. City,	Town or Lo	cation						10d. I	nside City Limits
	Mar Med sh	ţċ	MARYLAND DORC	HESTER				C	AMBR	IDGE	,		1	Yes 2 □ No
	th the	by Funeral Director	10e. Street and Number				10f. Zip	Code			10	g. Citizen of Wha	t Country?	
	ath w	la L	118 CHO	PTANK AV	/E				2161	13			USA	
	er de	nne	11. Marital Status	Was Deceded Armed Force	es?	13.	Was Deced If Yes, spec	ent of Hi	spanic Ori	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)	14. Race - A	American Ir Vhite, etc.	ndian,
36	s afte	Ϋ́	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Date		1	1 ☐ Yes 2		Specify:			Specify:		
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21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or Items 23e or 28e-f show ite Medical Evanimer must be notified at	Completed	(Specify only highest gra			(Give	kind of wor DO NOT us	k done a	luring mosi	t of worki	ing	ob. Ring of Busin	553/111045(1	у
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	al Hy al Hy d oth	Be (17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle, M	laiden Sumame)		
<u>у</u> а	Ment Ment arke	ို	RA	YNOR CR	OSBY						GRAC	E V. MILL	ΞR	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar then "naturel", or Items 23e or 28e-1 show any injury or other treumatic event, it a Medical Exambre must be notified at once.		19a. Informant's Name/Relationship (7			19b. Mailir						City or Town, Sta		
	1 and 1 and 1 and 27 3 m 27 3 m 27		ROBERT T. HAYE 20a. Method of Disposition	S / HUSBAI		an of Diana	113 sition (Nam		PTAN			IBRIDGE, M		
Baltimore,	ages or of		1 X Burial 2 ☐ Cremation 3 ☐		ate cem	netery, crer	natory or ot	her place	· I			Oc. Location - City		
틒	it. Partitude		 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen 		EASTER		VETERAN		1		7/2010	HUR	LOCK.	, MD
Ba	Depa Impo any ir		21. Signature of the land of t				. Name and				HOME DA 3	MODIFICATION	" A MDDH	DGE, MD 21613
,	Physician /Medical Examiner	Examiner	shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury	a	eumo as a consequer terem as a consequer	7/2 nce of):								inval Between set and Death
	and I-tran	хаш	that initiated events resulting in death) Last	c. CCL	as a consequer	ene/	10	11/6	ire				5	day5
760,	ate be executed nysician and he burial-transit	ical E		e m	ph ys	,	3						10	110115
687	ficate phys s the			d	Priyo	27716							100	1001-
.O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Woo 9 □ Unknow#		n 2 ☐ Fetal de t at time of deat	eath 3	Ectopic pre Other (spe					23d. Date of Month	delivery Day	Year
ecords, P	w requires that been signed b should be deta	by	Part II. Other significant conditions of Chronic Kidne		h but not resultin	- 1	nderlying ca	1.	n in Part I.	in	23e. Did toba	acco use contribut		use of death?
900	aw re	Completed	deficiency	/				/			24a. Was an		autopsy f	indings available
r		E O	J								autopsy perform 1 Yes 2		٦?	tion of cause of
Vital	sicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?						26. Place	of Death	(Check only one			
	Physia this car	2	1 □ Yes 2 No	Hospital: 1 Minp			t 3□ DO/	Othe	r: 4□Nui	sing Hon	ne 5 🗆 Resider	nce 6 Other (5	Specify)	
Division of	utending F death. ctor: After y the funera	atlon:	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of I (Month,	njury 28 Day Year)	Bb. Time of Injury	М 28	lc. Injury Work 1 Y			8d. Describe hov	v injury occurred		
Š	or fiter	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of building	Injury - At home etc. (Specify)	e, farm, stre	et, factory,	office		2	28f. Location (Stre City or Town,	eet and Number o. State)	r Rural Rou	ite Number,
	To the Hospitel within 24 hours a To the Funerel C completely filled i	Medical	29a. Certifier 1 Certifying Phy 2 Medical Exem	sician: To the be ner: On the basi and manner	s of examination	dge, death and/or inv	occurred a restigation,	t the time in my opi	e, date and inion, deat	d place, a h occurre	and due to the cau ad at the time, da	use(s) and manne e and place, and	r as stated. due to the	cause(s)
	To the within 2 To the complet	2	29b. Signature and title of certifier	> 9 1			29c.	License	number		29	d. Date signed (M	onth, Day,	Year)
•			spans	on a	U			1100	159	97	3	11/15/	10	
			Postrice Sonn	SON	of death (Item 23	3a) (Type, I	Print)	if,	Can	nbi	o idgi,	MD		
	Sta Registra		31. Date filed (Month, Day Yes 3	010 32.	strar's Signatur	a. A	ave							

			for State	State	of Marylar		artment of		and M	lental Hy	giene	0:0	00000
			Registrar 1. Decedent's Name (First, Middle	(ast)		Cer	tificate of	Death			Reg. No.	UIU	36822
	Physicia		The bed and that it was, what is		e Patri	cia Ha	rshman			2. Date of De Month	Day	Year	3. Time of Death
-	Medic Examin		4a. Facility Name (if not institution,	give street and nur	nber)		4b. City, Town,	or Location	of Death	Novemb		2010 County of Death	4:30 A M
			Williamsport N	ursing Ho	ome			liams				Washing	ton
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 X F	7. Age (In yrs.		If Under 1 Year Months Days		24 Hrs. Min.	8. Date of Birt (Month, Da		9. Birthp	place (State or Foreign
	Director		214-34-2353 Usual Residence of Decedent		77	Yrs.	IVIOITUIS Days	Tiours	IVIIII.	June 2	7, 19	33 Count	ryland
	and show at	o	10a. State 10b. County		10c. Ci	ty, Town or Loc	cation					1	0d. Inside City Limits
	//dary	rect	Maryland Was	hington			Hage	rstow	n				1 ☐ Yes 2 🛣 No
	the N	٥	10e. Street and Number				10f. Zip Code			Т	10g. Citize	en of What Coun	try?
	ıs 23% nust b	Funeral Director	13624 Rockcli	ff Drive			21	742				U.S.A.	
	death r item ner n	Ē	11. Marital Status	Armed Fo	edent Ever in U.		Vas Decedent of I	lispanic Ori	gin? (Spec	cify Yes or No- Rican, etc.)	14	4. Race - Americ	
36	after al", o	d b	1 ☐ Never Married 2 ☐ Marr 3 🌠 Widowed 4 ☐ Divorced	If Yes, Giv	re	1	☐ Yes 2 🟋 N	Specify:		, ,	Sa	Black, White, e	
21215-0036	hours natura lical E	Completed by	15. Deceder	Year or Date of the Year or Date of The Year o	-	16a. Deced	lent's Usual Occu	oation				d of Business Inc	
218	in 72 e. nan "r	щć	(Specify only highe Elementary/Seconday (0-12)	st grade completed, College (1		(Give k	kind of work done O NOT use retired	durina most	t of workir	ng	TOD. KIIK	d of Business inc	dustry
7	J with ygien her th	č			1	Data	Entry C	lerk			Publ	lishing	Company
and	e filec atal H ed ot	To Be	17. Father's Name (First, Middle, L Herbert John	· ·						(First, Middle,	<i>Maiden S</i> u	ırname)	
څ	ould b d Mer mark natic	_				_					_		
Maryland	2 sho Ith an 27 is 'trau		19a. Informant's Name/Relationsh Jennifer Feeser		ter)		g Address (Street Rockcli						
ē,	1 and f Hea item other		20a. Method of Disposition	- (Daugii	20b. F	Place of Dispos	sition (Name of			ate		ation - City or To	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2 □ Cremation Donation 5 □ Other (S)		State	cemetery, crem Ceda.	natory or other pla Lawn	ce)	Nove	ember 2010		•	Maryland
alti	rmit. I partin porta y inju		21. Signature of Funeral Service L		MO 1 4	lemoria	. Name and Addre	ss of Facilit				uneral	
<u> </u>	9 2 E E 6		Jeller fee	. Davis		1.	2525 Bra	dbury	Ave.	. Smith	sburg	, Maryl	and 21783
		5,4	23a. Part 1. Enter the disease, or shock, or heart failure. List o	complications that only one cause on ea	aused the deat ch line.	h. Do not ente	r the mode of dyi	ng, such as	cardiac or	respiratory arr	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Au	LITE N	MOCAR	DIAL I	NFAR	CTIC	NC		1	Onset and Death
	Medical Examiner		resulting in death)		or as a consequ	. '	- 54	N	-\	-			
		er	Sequentially list conditions, if any, leading to immediate	b. ———	or as a consequ		ERY	12156	ASE	5			
	ted Insit	amin	cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a consequ	uence on.							
	execu in and ial-tra	Ex	that initiated events resulting in death) Last	CDue to (or as a consequ	uence of):							
00	cate be executed physician and s the burial-transit	edical Examiner		d									_
924	rtifical ing ph e as th		IF FEMALE:				· · ·						
9 X	th cer ttendi	Physician/M	23b. Was decedent pregnant in the past 12 months?		Birth 2 🗌 Feta	al death 3 🗌	Ectopic pregnan	су			23	d. Date of delive	•
m	the a	iysid	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregi	nant at time of o	death 5 □	Other (specify)		-		_	Month	Day Year
Ö.	hat the ed by detac	by Ph	Part II. Other significant condition	ns contributing to d	eath but not res	ulting in the ur	nderlying cause gi	ven in Part I		23e. Did to	bacco use	contribute to the	e cause of death?
S,	uires t n sign ald be	q pe	CHRONIC OTSS	TRUCTIV	E Pui	MONA	EY DI	SEAS	E	1 🗆 Y	res 2 🗆	No 3 🗆 Prob	ably 4 🕰 Unknown
Ö	w req	plet								24a. Was a	an ;	24b. Were autop	sy findings available
3ec	The la	Completed								autop: perfor	med?	prior to con death? 1 \sum Yes 2	npletion of cause of
<u>e</u>	striffica ctor, p		25. Was case referred to medical examiner?				26. P	ace of Deat	h (Check d		Z Z NO		Z L NO
\equiv	hysic this co	욘	1 ☐ Yes 2 🗷 No		Inpatient 2		: 3 □ DOA Oth	er: 4 X Nu	rsing Hom	ne 5 🗆 Reside	ence 6	Other (Specify)	
Ö	ding F h. After funera	Certificate:	27. Manner of Death1 X Natural 5 ☐ Pending		of injury h, Day, Year)	28b. Time of injury	28c. Injur worl	(?		8d. Describe ho	ow injury o	ccurred	
Sio	Atten deat ctor: y the	≝	2 Accident Investig	ot be	of Injuny - At ho	me farm etre	M 1 L et, factory, office	Yes 2 🗌					
Division of Vital Records, P.O. Box 68760	al or / s after I Dire		4 ☐ Homicide determin		ng, etc. (Specify		et, ractory, office		2	City or Town		lumber or Rural F	Route Number,
_	ospita hours unera	Medical	29a. Certifier 1 Certifying	Physician: To the be	est of my knowl	edge, death o	ccured at the time	, date and p	lace, and	due to the cau	se(s) and n	manner as stated	d.
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as		only one) 3 Certifying	aminer: On the bas Nurse Practioner: 1	is of examinatior	n and/or investi	gation, in my opini	on, death occ	curred at the	he time date an	nd place, an	nd due to the caus	ea(c) and manner etated
	S TO S		29b. Signature and title of certifier	1			29c. Licens			1		signed (Month, D	
			MAN	y. M)			3700		/	VOUE	MRER 15	5, 2010
			30. Name and address of person w	_	A A			LIAM	EPAD	T. M		21795	
	State	e	31. Date filed (Month, Day, Year)		egistrar's Signat			-UHIII	DIVK	-1, 111		01/10	
	Registra		NOV 23	2010	wa s	9. par	Kar						

DHMH 17 Rev 7/2009

			Amend #1, po	Please er MD	Type or	Print in 2/2/10 Marylar	Black II	ndelibl	le Ink	c. Ens	ure A	All Copie	es Ar	e Legi	ible.			
			For State Registrar		Otato t	Certificate of Death						Reg. No. 36823						
			1. Decedent's Name (First, Middle, Last) Margaret Levina Hooton 2. Date of Death								eath			3. Time of Death				
	Physicia Medic		THE PROPERTY OF THE PROPERTY O									4, 2	δίο	12:30 PM				
	Examir		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death											rford				
	Funeral		5. Social Security Number	7. Age (In yrs.	Age (In yrs. last birthday) If Under 1 Year			If Under 24 Hrs. 8. Date of Birth			irth	9. Birthplace (State or Forei						
	Director		215-16-710 Usual Residence of Decede				89 Yrs.			Hours	Min.	11718	11/18/1920		Maryland			
	yland -f shov ed at	ctor	10a. State 10b. C			10c. City, Town or Loc										10d. Inside City Limits		
	r 28a	Jire	MD. 10e. Street and Number	Hari	ord	ord			Stree				10g. Citizen of What			1 Yes 2 X No		
	i and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ral	4400 Madonna Road					21154								States		
		Funeral Director	11 Marital Status 12. Was Decedent Ever in U.S.						3. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)							14. Race - American Indian,		
36		by	1 Never Married 2 3 Widowed 4 Div	rces2 2 X No re	2. K No			lf Yes, specify Cuban, Mexican, Puerto Rica 1 □ Yes 2 🏿 No <i>Specify:</i>				Black, White, etc. Specify:						
8		etec		orced ecedent's Edi	Year or Da	ates.								Specify: White				
Maryland 21215-0036		Completed	(Specify only Elementary/Seconday (0	(Give	Give kind of work done during most of working fe. DO NOT use retired)													
21		Be Co	12 0							Housewife						Home		
and		To B	17. Father's Name (First, Middle, Last) Elias Detweiler Bamberg						18. Mother's Name (First, Middle, Ma						anks Logan			
Z			19a. Informant's Name/Rela	7	r Bertha Ban ng Address (Street and Number or Rural Route Number, City													
	d2sh althai ກ27is ertrau		Gary Duran			(Son)		4 Scl						у На				
Baltimore,	of Health of Health fitem 27		20a. Method of Disposition 1 X Burial 2 Crem	ation 2 🗆 I	Pomoval from	20b. I	Place of Dispo	sition (Nam	ne of ther plac	e)]	Nov.	Date 18,	20c.	Location -	City or 1	Town, State		
ij	trent trent tant: jury c		4 Donation 5 0	ther (Specify)			ir Me			ens	20	010				Maryland		
Bal	permit. Page 1 a Department of H Important: If ite any injury or oth		21. Signature of Funeral Service Vicensee (Land Land Land Land Land Land Land Land															
			23a. Part 1. Enter the disea	se, or compl	ications that	aused the deat	th. Do not ent	er the mode	e of dying	g, such as	cardiac	or respiratory a	SVI	TIE.	Ma	Approximate		
	Physician/	Completed by Physician/Medical Examiner	shock, or heart failure. List only one cause on each line.															
	Medical Examiner		Due to (or as a consequence of):									GRds-						
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		Sequentially list conditions, if any, leading to immediate		Due to	Due to (or as a consequence of):								ase	,	0 5		
			cause. Enter Underlying Cause (Disease or iinjury that initiated events	(d'as'a consequence of):								6		7cors				
			resulting in death) Last Due to (or as a consequence of):															
200			d															
Box 68760			IF FEMALE: 23b. Was decedent pregnan			c. If yes, outcome of pregnancy 1					VA		23d. Date	23d. Date of delivery				
		ıysici	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		4 🔲 Preg								Month Day Year					
P.O.		y Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23e. Did tobacco use contribute to the cause of death?												the cause of death?			
		npleted b	Chronic ATRIAC FIRPIllaters 1 yes 2 No 3 probably 4 Unknow 1 yes 2 No 3 probably 4 Unknow 24a. Was an autonsy prior to completion of cause of												obably 4 🗆 Unknown			
COL	aw recias bee		ncysl, proteines 24a. Was an autopsy findings available prior to completion of cause of															
Re	The l											1 Yes	formed?	No 1	eath?	2 🗆 No		
ital	or Attending Physician after death. Director: After this certifi in by the funeral director	To Be	25. Was case referred to me examiner? 1 Yes 2 No		ospital:		26. Place of Death (Check only one) 10 2 ER/Outpatient 3 DoA Other: 4 Nursing Home 5 Residence 6 Other (Specify)											
Division of Vital Records,			1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 0 0 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occi									6 Other	r <i>(Specit</i> d	y)				
on		ficat	2 Accident Ir	Pending rvestigation		28b. Time of injury (Month, Day, Year) 28b. Time of injury M 28c. Injury at work? 1 \(\triangle \text{ Yes} \) 2 \(\triangle \text{ No} \) A												
ivisi		Certi		Could not be etermined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)							
Ω	hours hours ineral l	Medical Certificate:				To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
	the Ho nin 24 the Fu		(Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
_	To vitt		29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)															
)		30 Name and address of person who completed cause of death (Itam 22a) (Time Print)															
			29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11/16/2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3805 NORRISVILLE PLOY 31. Date filed (Month, Day, Year) NOV 2 3 2010 32. Registrar's Signature 1. Land															
	Stat	е	31. Date filed (Month, Day, Y	v 2.3))1) ^{32. R}	edistrar's Signa	ture	back	1		11			1				

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

MUNA

		State of Maryland / Depa				
	_	1 - State Registrar Cer	tificate of Death		eg. No.2 0 1 0	36825
Physicia	_	1. Decedent's Name (First, Middle, Last) CLARA MARIA HAMMON	10	2. Date of Deat Month	Day Year 10	3. Time of Death 7:59 P M
/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of De	eath	4c. County of Dear	
No.		3459E SUNFLOWER PLACE 5. Social Security Number 1/4 6. Sex 7. Age (In yrs. last birthday)	WALDORF, M.			LES hplace (State or Foreign
Funeral Director		5. Social Security Number (A) 6. Sex 1 □ M 2 ▼ F 78 Yrs.		lin (Month Day	3-1932	industry) ITALY
and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	cation			10d. Inside City Limits
Marylan a-f show	ţo	MD CHARLES WALDON				1 ☐ Yes 2 No
death with the Maryland	Director	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What Co	•
eath w	Funeral	3U59E SUNFLOWER PL. 11. Marital Status 12. Was Decedent Ever in U.S. 13. V	20602 Vas Decedent of Hispanic Origin?	(Specify Yes or No-	ENGLAN 14. Race - Ame	
after d		Armed Forces?	Yes, specify Cuban, Mexican, Pu ☐Yes 2 MNo Specify:	uerto Rican, etc.)	Black, White	e, etc.
S E B	ed by	3 ☑ Widowed 4 ☐ Divorced Year or Dates:	lent's Usual Occupation		Specify: 4)HITE
i within 72 ho jiene. r than "natur in wedien!	Completed	(Specify only highest grade completed) (Give	kind of work done during most of v OO NOT use retired)		TOD, KING OF BUSINESS	industry
ed within lygiene. ner than '		12	HONEMA		HOMEN	AKER
x -	o Be	17. Father's Name (First, Middle, Last) LUIGI DIMARTINO		Name (First, Middle, M	,	
shou and M s mar umat	၉		g Address (Street and Number or			Zip Code)
and 2 lealth a m 27 is		MARILYN DOYLE, Daugnese	3459E SUNFLE		20c. Location - City or	
Pages 1 nent of H ant: If ite ury or ot		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	natory or other place)		•	
业世世帝.		4 □ Donation 5 □ Other (<i>Specify</i>) 21. Signature of Funeral 25 vice Licenses 22	Name and Address of Facility	10 acrop	HANOVER	TAD
Depa Impo any I		Cafe 34	1596 SUNFLOWE	e PLACE,	WALOCK	
		23a. Part 1. Enter the disc sie, over mplications that caused the death. Do not enter shock, or heart fallure. List only one cause on each line. Immediate Cause (Final				Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death) Due to (or as a consequence of):) Dem	0~5-6		
Examiner		Sequentially list conditions b.				
rted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
		that initiated events c				
cate be ohysicia the buri	dical	d				
leath certificate attending physi I for use as the b	Physician/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy	_		23d. Date of de	livery
death e atte	sicial	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 5	Ectopic pregnancy Other (specify)		Month	Day Year
hat the		9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the ur	derlying cause given in Part I.	23e. Did tol	pacco use contribute to	the cause of death?
w requires that the de been signed by the should be detached	od by		-	_ 1 🗆 Ye	es 2 No 3 P	robably 4 Unknown
law relas bee	Completed			24a. Was a	v prior to	utopsy findings available completion of cause of
sician: The law s certificate has b irector, page 2 s						3 2 □ No
ysician s certii directo	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 □ No Hospital: 1 □ Inpatient 2 □ ER/Outpatien	Other:	Death <i>(Check</i> o <i>nly</i> or o Home 5 ☐ Reside	ence 6 DOther (Spe	
Ing Ph	D:T	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Injury	Work?	28d. Describe ho	ow injury occurred	
Attend death ctor: / y the f	ficati	2	M 1 ☐ Yes 2 ☐ No eet, factory, office	28f. Location (St	reet and Number or R	ural Route Number,
tal or restriction all Direction bed in b	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town	n, State)	
	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death of the basis of examination and/or in and manner stated.	n occurred at the time, date and pl vestigation, in my opinion, death o	lace, and due to the o occurred at the time, d	eause(s) and manner a late and place, and due	s stated. e to the cause(s)
To the within comment of the the comment of the the the the the the the the the the	Ž	29b. Signature and title of certifier.	29c. License number	7	9d. Date signed (Mont	th, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a) (Type, I	Lollad	a M	020	646
Stat Registra	-	31. Date filed (Month, Day, Year) 2 3 20 10 Registar's Signature A.	pare			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	_ For		State of	iviaryiani	u / Dep	artifient of i	realth and i	vientai my	giene			
	1 - State Registrar				Ce	rtificate of l	Death		Reg. No.	0	0	36827
n/	1. Decedent's Name	e (First, Middle, L Jerome	ast) Jose	ph		Hurley		2. Date of De Month Novemb		1, 2ď	Î ro	3. Time of Death 11:45 a. _M
er	4a. Facility Name (# Brooke G. Nursi 5. Social Security No.			on and	l		r Location of Death Spring	1		County of D Montg		ry
	5. Social Security No. 225–10–4		Sex XX M 2 □ F	Age (In yrs. la	st <i>birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird FED**				lace (State or Foreign Ginia
	Usual Residence of	Decedent										
ō	10a. State	10b. County		,	, Town or L	ocation					1	0d. Inside City Limits
rect	MD	Montg	omery	0	lney							1 🗆 Yes 2 💹 lo
Funeral Director	10e. Street and Nun 3608 Ki		am Drive	·		10f. Zip Code 2083	2			en of Wha		try?
Completed by Fun	11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed	ied 2 XX Married	12. Was Decede Armed Force XX Yes 2 If Yes, Give Year or Date	s? □ No WWT		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 XX	an, Mexican, Puerto	pecify Yes or No- o Rican, etc.)		4. Race - A Black, V pecify:	Vhite, e	
set	(Sne	15. Decedent's	Education grade completed)		16a. Dece	edent's Usual Occup	pation	bina	16b. Kin	d of Busin	ess Inc	lustry
	Elementary/Seco		1 College (1-4	or 5+)	life. I	les manag	•	NIIG	Cer	ment	com	pany
To Be	17. Father's Name (i		seph		Hurle	У	18. Mother's Nan Kathe		Maiden Si There		Н	opkins
	19a. Informant's Na Mary T	me/Relationship Hurley				ing Address (Street King Wil						Code)
	20a. Method of Disp		Removal from St	C6	emetery cre	osition (Name of matory or other pla Cenetery	^{ce)} 11/2	Date 20/2010		ation - Cit	,	wn, State

Physician/ Medical **Examiner**

within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last

in the past 12 months?

1 Yes 2 L 9 Unknown

Signature of Funeral Service Licensee

23a. Part 1. Enter the disease, or o shock, or heart failure. List on	complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ally one cause on each line.
Immediate Cause (Final disease or condition	- FNDSTAGE CONGESTIVE HEART FAILURE
resulting in death)	Due to (or as a consequence of): RIGHT HEART FAILURE
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of): CHD NAMY (TRETD) ATTURE RAI MANAGEY DESERVE.

95 Union St

Due to (or as a consequence of):

YEARS

Day

1 ☐ Yes 2 ☐ No

Year

Approximate Interval Between Onset and Death

Exam Physician/Medical IF FEMALE: 23b. Was decedent pregnar P Completed by Be 25. V မ 27. N Certificate:

3

31. Date filed (Month, Day, Year)

nt	23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death
	4 Pregnant at time of death
	9 IInknown

3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____

M00522

23d. Date of delivery

22. Name and Address of Facility Helsley-Johnson Funeral Home, Inc.

Berkeley Springs,

art II. Other significant conditions contributing to de	eath but not resulting in the underlying cause g	iven in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 XXN

Vas case referred to medical xaminer?					
1 Yes 2 No	Hos	spital: 1 Inpatient 2	ER/Outpatient	3 🗆 1	DOA
lanner of Death		28a. Date of injury	28b. Time of		28c

26. Place of Death (Check only one) Other: 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28c. Injury at 28d. Describe how injury occurred

21713

Natural Accident	5 Pending Investigation	(IVIONTH, Day, Year)	injury	М	work? 1 \square Ye				
☐ Suicide ☐ Homicide	6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							

2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occur	red at the time, date and place, and due to the	cause(s) and manner as stated.					
(Check 2 Medical Examiner: On the basis of examination and/or investigation	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner sta						
only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death	occurred at the time, date and place, and due to	the cause(s) and manner as stated.					
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)					
18/10/10 11	1227M	1 /2 /2 /2 /2 /2 /2 /2 /2 /2 /2 /2 /2 /2					

55700

29d. Date signed (Month, Day, Year)

	_		J								
								44.	1	_	
30.	Name an	id address	of person	who	completed	cause of	death	(Item	23a)	(Type,	Print)
								,	,	, ,, ,	,

red E. Hour 154N, ARTIZAN ST. WILLIAMSTORT

State Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 3PM M 201C ovemb Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Plata 0 a 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth Funeral Months Days Hours 4 (Moztr3 Day 1994 7 PAountry) 63 **Director** Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County Director 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f s event, the Medical Examiner must be notified LA PLATA MD. CHARLES 1 Xes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 9175 PARKWAY SUBDIVISION RD. 20646 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2X No Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 Specif WHITE 1 ☐ Yes 2 ☐XNo Specify. If Yes, Give 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) th and Mental Hygiene. 27 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည ROBERT JAMES MENSER DORIS ARLENE HAY Page 1 and 2 should be ment of Health and Menta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Department of Health ar Important: If item 27 is any injury or other trau THOMAS J.LACHANCE-SPOUSE 9175 PARKWAY SUBDIVISION RD. LA PLATA, MD. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State INITY MEM. GARDENS 11-18-10 WALDORF, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Foreral Service Licensee M00479 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death NEWHONE Immediate Cause (Final Physician/ Medical resulting in death) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 WNo 23d. Date of delivery Day Month Year Yes 2...
Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 3 Probably 4 Unknown Records, 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 🗌 Yes 2 🔲 No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Division of Vital Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check ertifying Nurse Practioner: To # best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title 29d. Date signed (Month, 0/0 Waldorf, MD State Registrar

		I	mend 20b	Plea per f	se Type on the g910 l	or Pri	nt in B	lack In	ndelible In	k. Ensure A Health and N	All Copie Mental Hy	s Are L	.egible.	
		•	For State Registrar		Otate	OI IVI	ai yiai ia		tificate of L		vicinairiy	Reg. No.	201	0 36829
	Physicia	ın/	1. Decedent's Nam				,	-			2. Date of De Month		Year	3. Time of Death
	Medic	cal			berts Mi		ign ———				Octobe			7:12 A ^M
4	Examin	er	4a. Facility Name (if		, give street and r rove Cou	,				City, Town, or Location of Death Millersville Anne Arundel				
	Funeral		Social Security N	umber	6. Sex 1 ☐ M 2 🔀	7. Ag	e (In yrs. last		If Under 1 Year Months Days		8. Date of Bir (Month, Da		9. Birt	thplace (State or Foreign untry)
	Director		218-42-7 Usual Residence of		m		64	Yrs.			Dec. 1	1,1945		aryland
	f shov	tor	10a. State	10b. County	~	·			or Location					10d. Inside City Limits
	e Man r 28a- notifie	Director	MD 10e, Street and Nur		Arundel	_	MIL.	TTELS	10f. Zip Code			10 0"	n of What Co	1 Yes 2 XNo
	with the 23a o	Funeral 1			rove Cou	rt			21108 Us					untry?
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed		ried Armed	Forces? es 2 2 Give	Ever in U.S.		Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Spo an, Mexican, Puerto Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15-0	"2 hou "natu edical	Completed	(Spe	15. Decede ecify only highe	nt's Education est grade complet	ed)	I	(Give k	lent's Usual Occup	ation during most of work	ing	16b. Kind	of Business	Industry
212	vithin 7 jene. er than the M		Elementary/Sec		College	(1-4 or 5	5+)		O NOT use retired) memaker		H H	ome		
pu	e filed v ntal Hyg ed othe event,	To Be	17. Father's Name (•					18. Mother's Nam Elsie R				S
Maryland	ould by market market	-	Thurman 19a. Informant's Na	<u>-</u>				19h Mailin	a Address (Street	and Number or Run				
, Ma	nd 2 sh saith ar n 27 is er trau				jh / Husk	and		338	Redwood (Grove Cou	rt Mil	lersvi	ille,	MD 21108
Baltimore,	ge 1 ar nt of He : If iter or oth		20a. Method of Disp 1 X Burial 2	Cremation	3 🗌 Removal fr	om State	20b. Plac	ce of Dispo netery, crem	sition (Name of natory or other plac	ce) 1/1	Date 2/4		tion - City or	
Iţi	nit. Pag artmer ortant injury		4 ☐ Donation 21. Signature of Fu				Arli	ngton	National	l Cemeter	y 2011		ngton,	
Ba	permit Depar Impor any in			ignature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146										
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
	nysician. Medical	17	Immediate Cause (disease or condition resulting in death)		_ a	Ng		e to	cort.	FAILSA			- 0	Set and Death
कर्ती	Examiner				T Co	NO (No	a consequer	nce of	Loca D	N-SENO				2 Sam
	p #	niner	Sequentially list co if any, leading to in cause. Enter Unde	rlying	Due	to (or as	a consequer	nce of):	U					, = 00
	executed an and rial-transit	Examine	Cause (Disease or that initiated event resulting in death)	S	c. Due	to (or as	a consequer	nce of):				·		
0		 			d									
68760	rtificat ing ph e as th	Med	IF FEMALE:		1									
Box 6	Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. 24 hours after death can be the continuation of the content of the c	Physician/Medic	23b. Was decedent in the past 12 1 ☐ Yes 2 5 9 ☐ Unknown	months?	1 □ Li 4 □ P	ve Birth	of pregnanc 2 Fetal of at time of dea	death 3 L	Ectopic pregnand Other (specify)	СУ		230	d. Date of del Month	livery Day Year
P.O.	s that the		Part II. Other signif	R		death b	out not result	ting in the u	nderlying cause giv	ven in Part I.	23e. Did to	obacco use	contribute to	the cause of death?
rds,	requires the been signed should be	ted	Chron	C 10	NO 1	0110	RL				1 🗆			robably 4 Munknown
Records,	has be	Completed by									24a. Was autop	nsv	4b. Were aut prior to death?	topsy findings available completion of cause of
E A	sician: The law I certificate has k irector, page 2 s	Be Co	25. Was case referre	ed to medical					26. PI	ace of Death (Chec.	perfo 1 ☐ Yes	2 No	1 Yes	2 □ No
of Vital	hysician: nis certific I director,	To B	examiner?				ent 2 🗆 EF	R/Outpatien	Oth			dence 6	Other (Spec	ity Hospig
n of	ding Pl h. After ti funera	ate:	27. Manner of Deat	5 Pendir	ng (M	te of inju	ry 28 y, Year)	8b. Time of injury	28c. Injun work M 1 🗆	yat ? Yes 2 □ No	28d. Describe h	now injury oc	curred	
Division	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completed filled in by the funeral.	Certificate:	2 Accident 3 Suicide 4 Homicide	Investi 6	not be 28e. Pla	ice of Inju	ury - At home	e, farm, stre	eet, factory, office	ies 2 🗀 NO	28f. Location (S		umber or Rui	ral Route Number,
Δ	spital o sours af neral Di		29a. Certifier 1	Certifying				lge, death o	occured at the time	, date and place, ar			nanner as sta	ated.
	the Ho hin 24 h the Fur mpleted	Medical	(Check 2	🛚 🗌 Medical E	xaminer: On the	oasis of e	xamination a	nd/or investi	igation, in my opinio	on, death occurred a e time, date and plac	t the time, date a	and place, and	d due to the o	cause(s) and manner stated.
	Veith Com		29b. Signature and	title of certifier	, All	110			29c. License	e number	302	29d. Date s	igned (Mogth	n, Day, Year)
	21/		30. Name and addr	ess of person	who completed o	ause of d	eath (Item 2)	3a) (Tivne P	rint)	1070	N 2	11/	2/1	Anatolis
_	>		MARCO	A-M	lexa.	N.D	200	22 1	nedryl	TANKE	4 Jul	+ 3	12	pro
	Stat Registra		31. Date filed (Mont	NOV 0	3 2010 32	. Fegistra	ar's Signatur	9. A	arke	4		2.77		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 28, 2010 James William Moore, Jr. 10:00 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5911 Harland St. Prince George's Lanham Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, 1) | Sept. | 8 | 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign Funeral Year 938 Maryland 212-36-2165 Director 72 Yrs. Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Lanham 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5911 Harland St. 20706 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 X Yes 2 Black White, etc. and Mental Hygiene. is marked other than "natural", or i 1 Never Married 2 Married Completed by 2 No 1 ☐ Yes 2 🖾 No Specify: 3 Widowed 4 Divorced If Yes. Give Specify: White Year or Dates.1961-63 traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Music Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James William Moore, Sr. Rose Shorb 1 and 2 should be of Health and Meritem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen L. Moore 5911 Harland St., permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr / Spouse Lanham, MD 20706 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ₭ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem 11/4/2010 Crownsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 23a. 6 rt 1. Enter ty dis shock, or he failu Immediate Cause (Final disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ constitue heart failure 0055101E disease or condition Medical Examiner resulting in death) ue to (or as a consequence of): Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Ordenying Cause (Disease or iinjury that initiated events that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Year Pregnant at time of death 5 Other (specify) Day 1 L Yes 2 L 9 L Unknown been signed by the should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 performed 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital Other: 2 1 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending (Month, Day, Year) 1 Matural 5 Pending work?
1 Yes 2 No n 24 hours after death.

e Funeral Director: Aft
bleted filled in by the fur Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie 1 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier

State

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

816 Good Luck Rd.

Lanham, mo

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ASEEM

31. Date filed (Month

USSAIN

Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of	Marylan	d / Depa <i>Cer</i>	artment of F	lealth and Death	d Mental Hy	giene2		36831
		1. Decedent's Name (First, Middle,	Last)					2. Date of De	eath		3. Time of Death
Physic /Med		William			M	ccawle	V	Month	Day 30	Year 2010	15:20 M
Exami		4a. Facility Name (If not institution,	give street and numb	per)		4b. City, Town, or		eath	4c. County	y of Death	
4		The Johns Hopkins				Baltimore			Non		
Funeral		,	6. Sex 7 1 ☑ M 2 ☐ F	'. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 I Hours N	lin. (Month, Da	ay, Year)	Country)	
Director		214-60-5375 Usual Residence of Decedent		57				April 9	1953	Maryl	and
yland how		10a. State 10b. County		10c. City	, Town or Lo	cation				100	d. Inside City Limits
e Mar a-f s	cto	MD Anne A	rundel	Cro	fton						1 ☐ Yes 2 🔀 No
or 28	Director	10e. Street and Number				10f. Zip-Code			10g. Citizen of	What Country	?
ath w s 23a ust b	la	1508 Pearl Ave.				21114	_		USA		
er de	Funeral	11. Marital Status	12. Was Deced	ces?	S. 13. \	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race Blaci					
Is aft	by	1 ☐ Never Married 2X Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 If Yes, Give Year or Date		1	1 ☐ Yes 2 X No Specify: Specifi					ite
2 hou atura		15. Decedent'	s Education		16a. Deced	Decedent's Usual Occupation 16b. Kind					
hin 73	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4	or 5+)	(Give	kind of work done of OO NOT use retired	during most of)	1		110	
d wit	5	12			Agen	.t			Real E		
be file tal Hy d oth	Be	17. Father's Name (First, Middle, La	_				18. Mother's	Name (First, Middle	e, Maiden Surnai	me)	
y a ould Men arke	ျ	Francis Xavier I			1			aret Ann			
VICAL 12 sh n and 7 is m raum		19a. Informant's Name/Relationshi Deborah J. Barga		:e	1	ig Address (Street Pearl Ave		r Rural Route Numb rofton, N			ode)
1 and Healt Healt em 2	-	20a. Method of Disposition	————		<u> </u>	sition (Name of		Date	20c. Location		State
ages intof		1 ☐ Burial 2X Cremation 4 ☐ Donation 5 ☐ Other (Sp.		ate c	emetery, cren	natory or other place		/8/2010	Baltim	•	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Services		ric				Beall Fur			
and de de de de de de de de de de de de de	ŀ.	1/en///				6512 NW (ie, MD	20715	
		23a. ar 1. Enter the hease, To	omplications that cau	used the death	. Do not ente	er the mode of dyin	g, such as car	diac or respiratory	arrest,		pproximate nterval Between
Physician		Immediate Ca (Final disease or condition	Hyr	ocxio							Inset and Death
/Medical		resulting in death)	Due to	r as a consequ	1000	,					
Examiner	<u>.</u>	Sequentially list conditions.	b. Me	tas tout		ectal C	arcin	oma			
sit s	nin.	Sequentially list conditions, if a y, seeing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Dule to (o	ras a our sequ	lenes 51).						
be executed iician and burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (o	r as a consequ	ence of):						
ate be executed hysician and the burial-transi	dical		d.								
ficate t physical physical	0										
eath certifica attending ph	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregna	,	Ectopic pregnancy			23d. Da	ate of delivery	
death e atter ed for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No		nt at time of de		Other (specify)			Mo	onth Da	ay Year
at the by the etach	Phy	9 Unknown Part II. Other significant condition			olaine in about		on in Don't	00. 011			
The law requires that the death certific to has been signed by the attending page 2 should be detached for use as	þ	Tattii. Other significant condition	is community to dea	an out not rest	aning in the u	noenying cause giv	ven in Part i.	23e. Dia	tobacco use con Yes 2 No	3 Probab	
requi	etec		_					24a. Was			
e law has b	Completed							l auto	psy ormed?	prior to comp death?	y findings available pletion of cause of
	ပို	25. Was case referred to medical				· · · · · · · · · · · · · · · · · · ·	26 Place of F	1 ☐ Yes Death (Check only of	2 No	1 Yes 2	□ No
Attending Physician; or death. ector: After this certification by the funeral director,	To B	examiner? 1 ☐ Yes 2 📉 No	Hospital: 1 King	patient 2 🗆 I	ER/Outpatient	3 □ DOA Othe		g Home 5 Resi		ner (Specify)	
era th		27. Manner of Death	28a. Date of		28b. Time of Injury	28c. Injury Work	/ at		how injury occur		
tending Ph leath. or: After thi the funeral	atic	2 ☐ Accident investiga	ition	Day roury	mjary		Yes 2 □ No				
r Atte ter de recto	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad 200. Flace 0	f injury - At hor j, etc. <i>(Specify)</i>	ne, farm, stre	et, factory, office		28f. Location City or Tox	(Street and Num, vn, State)	ber or Rural F	loute Number,
oltal o		29a. Certifier 1 Certifying	Physician: To the he	net of my know	dodgo doath	Occurred at the time	an data and al	and due to the			
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fur	edical	(check only one)	Physician: To the be xaminer: On the bas and manne	is of examinati	on and/or inv	estigation, in my o	ne, uate and pl pinion, death o	ace, and due to the occurred at the time	date and place	anner as stat , and due to t	ea. he cause(s)
orthin orthin omple	Med	29b. Signature and title of certifier	and mallie	. stated.		29c. License	number		29d. Date signe	d (Month, Da	y, Year)
F > F 0		1 GAR	3/			RE	5-00	00	Octobe.		2010
112		30. Name and address of person w	ho completed cause	of death (Item	23a) (Type,				- 400c	ے ح	2010
100		Edward Li.	2				60	0 North Wo	olfe St, Ba	ltimore	, MD, 21287
St Regist		31. Date filed (Month, Day, Year) $\begin{array}{c} \text{NOV 0 3 2} \end{array}$		istrar's Signatu							
riegisi	rai	1101 002	Level Charles	wa p	7. 100	eld					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 29,2010 Year Ryan Matthew MacCaull 2:15 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Hospice Center Towson Baltimore County 5. Social Security Number 6. Sex 7, Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 D F Months Davs Hours Min. Oct. 7,1979 **Director** 210-66-5331 31 York New Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland event, the Medical Examiner must be notified at Director Maryland Queen Anne's 1 🗌 Yes 2 👿 No Grasonville 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? Funeral 309 Whitehouse Drive 21638 United States items 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event. The Marken France. þ 1 X Never Married 2 Married 1 Yes 2 Maryland 21215-0036 1 Yes 2 No Specify: 3 🗆 Widowed 4 🗀 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Electronics Technician Dyncorp Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert William MacCaull Lillian Veronica Gunn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillian MacCaull / Mother 2636 Tantelon Place, Winston-Salem, NC Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 11/1/2010 Baltimore, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. . Signature of Funeral Service Licensee Mychin ldey 147 Duke of Gloucester St. Annapolis. MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Due to (or as a consequence of): Physician. disease or condition resulting in death) montho Medical Examiner Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 25. Was case referred to medical examiner? **Division of Vital** 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 A Other (Specify) 1 Yes 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA NUSPIO 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or inventioning in my principle death. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title 29d. Date signed (Month, Day, Year) October 29 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year) NOV 0 3 2010 N-Charles ST

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For AMEND#29c, 30 per PHY State AACO HEALTH DEPT. 11/3/2010 cmh Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death October Physician/ Margaret L. McCubbin 2010 12:45 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Arnold 1000 Placid Court Social Security Number . Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth
(Month, Day, Ye
Feb. 11, Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months Davs 220-24-8111 82 Director Maryland Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Arnold Anne Arundel MD 1 🗆 Yes 2 😾 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21012 1000 Placid Court Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic evem ပ Marie Cullender Franklin Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 135 Forest Street New Canaan, CT 06840 Thomas McCubbin / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date October 1 Burial 2 Cremation 3 Removal from State Baltimore, MD 4 Donation 5 Other (Specify) Metro Crematory, INC. 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home Severna Park, MD 21146 495 Ritchie Hwy 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Jement c that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the atte Month Year Pregnant at time of death ☐ Pregna... ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 2 No 3 Probably 4 Unknown 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) 24a. Was an has performed? within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 **N**No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury **≥**Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation πpleted filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital 24 hours a Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) CD0056088 10/27/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Lisa L Keithley

NOV

31. Date filed (Month,

1509

Ritchie Highway

32. Registrar's Signature

MD 21012

Arnold.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #26, per MD g910 12/14/10 TT

For State Registrar

Amend Items 24a,25,27,29a per dr.,2909,11/23/2010dnb

Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #26, per MD g910 12/14/10 TT

Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #26, per MD g910 12/14/10 TT

Certificate of Death for State Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 3:00 P M VICTOR GUST MYERS 2, 2010 NOV. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany 12316 Winchester Rd., SW Cumberland 9. Birthplace (State or Foreign Country)
Maryland If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Ye)
Jan. 21, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year Months Days 1**x** M 2□ F Yrs. 1951 214-62-2775 Director 59 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Director Allegany Cumberland MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number ō USA 21502-7605 12316 Winchester Rd., SW or items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 72 hours after 1 ∐Yes 2**X** No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important if filem 27 is marked other the any injury or other traumatic event, ITs.I. once. Disabled 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vienna J. (Hemming) Myers Clarence Myers ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 23165 Barley Court, Lexington Park, MD 20653-2193 Paul G. Myers 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Nov. 12, 10 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) Sunset Memorial Pk 22. Name and Address of Facility 21. Signature of Euneral Service Licensee Hafer Funeral Service, 1302 National Hwy., LaVale, MD 21502 23a. Part I. Enter the disea e, r complication that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should, or heart failure. Set only one of the one ach line. Approximate Interval Between Qnset and Death Immediate Cause (Final Carcinoma Physician uamou 6 months disease or condition resulting in death) /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ne that the death certificate be executed Examir burial-transi and Due to (or as a consequence of): attending physician for use as the burial Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No signed by the a P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Hospital or Attending Physician: The law requires t 2 1 Yes 2 No 3 Probably 4 Unknown is certificate has been s director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Nursing 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Heme- 5X Residence 6 ☐ Other (Specify) Certification: To this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral of 27. Manner of Death 1 Natural 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 ☐ Homicide Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 Nov. 3, 2010 D0023371 ress of person who completed capse of death (Item 23a) (Type, Print) 12502 Willowbrook Rd, Ste. 440, Cumberland, MD 21502 31. Date filed (Month, Day, Year) 2010 . Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 _ State	partment of Health and Mental Hygiene ertificate of Death
		Registrar 1. Decedent's Name (First, Middle, Last)	neg. No.
Physic Med		Nancy C. O'Neill	2. Date of Death Month Day Year October 28, 2010 12:05 PM
Exam		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death 4c. County of Death
		Prince George's Hospital Center	Cheverly Prince George's
Funera Directo	_	5. Social Security Number 171−28−0091 6. Sex 1 □ M 2 🖾 F 77 Yrs	Months Days Hours Min (Month Day Your)
		Usual Residence of Decedent	OCt. 23, 1933 Pennsylvania
/land f sho	į	10a. State 10b. County 10c. City, Town or	Location 10d. Inside City Limits
Mary 28a- notifie	Director	MD Prince George's Bowie	1 ☑ Yes 2 □ No
th the		10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?
ath w ems 2	Funeral	3416 Memphis Lane 11. Marital Status 12. Was Decedent Ever in U.S. 1	20715 USA 3. Was Decedent of Hispanic Origin? (Specify Yes or No-
6 ter de nite mine	by F	1 ☐ Never Married 2XXMarried Armed Forces? 1 ☐ Yes 2X No	If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc.
OO3	ed		1 ☐ Yes 2X☐ No Specify: Specify: White
15-(Completed	15. Decedent's Education 16a. De (Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of working
ithin rene.	اق اق	Elementary/Seconday (0-12) College (1-4 or 5+)	nist/Organist Music
Id Hyg	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Maryland 21215-0036 2 should be filed within 72 hours after tith and Mental Hygiene. 27 is marked other than "natural", o r traumatic event, the Medical Exam	욘	Harols Clough	Carrie Dietriech
should and the is misting and th		19a. Informant's Name/Relationship (Type, Print) 19b. Ma	illing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
e, N and 2 Health			16 Memphis Lane, Bowie, MD 20715
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 🔀 Burial 2 🗌 Cremation 3 🗋 Removal from State cemetery, ca	position (Name of Date 20c. Location - City or Town, State ematory or other place)
I ltin nit. Pa artme artme ortani injury		4 Donation 5 Other (Specify) MD Veter	ans Cemetery 11/1/2010 Crownsville, MD
Bal permi Depar Impol any ir		Jan 1	22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715
		23a, Part / Enter the disease, o complications that caused the death. D no e	nter the mode of ping, such as cardiac or respiratory arrast. Approximate
- Physician	/	stock, or heavitailure. List only one cause on each line. Immediate Caus Final disease or condition	Interval Between Onset and Death
Medica Examine		resulting in death) a. Due to locar a consequence of):	a singulation
LAGITITIE		Sequentially list conditions, b.	Oloshyel Jing Olsens
ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Unsease on injury)	Variet and
xecut	Exa	that initiated events resulting in death) Last C. Due to (or as a consequence of):	maries 5
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6876 ertificate iding physe as the	Med	IF FEMALE:	
th cert ttendii	ian/	23b. Was decedent pregnant in the past 12 months? 1 Live Birth 2 Fetal death 3	☐ Ectopic pregnancy 23d. Date of delivery
Box e death c the atten hed for u	Physician/Me	1 Yes 2 No 4 Pregnant at time of death 5 9 Unknown	Other (specify) Month Day Year
Hat the ned by detac	Y Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
S, Fuires the signer of the be	Completed by	Hypertanolo.	1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown
VITAI KECOTGS, sysician: The law requires lis certificate has been sig director, page 2 should b	olete		24a. Was an 24b. Were autopsy findings available
⊀eC The lare that the hare sage 2	m o		autopsy prior to completion of cause of death?
ian:]	Be	25. Was case referred to medical examiner?	1 Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one)
Vision is ce direction	P	1 ☐ Yes 2 ☐ No Hospital: 1 Inpatient 2 ☐ ER/Outpati	
_		27. Manner of De Ith 28a. Date of injury 28b. Time (Month, Day, Year) Injury Injury	
n of ding Ph h. After th funeral	ate	A Transfer of the Tolland	work?
SION OT Attending Ph death. ctor: After th y the funeral	rtificate	A Mccident Investigation 3 □ Suicide 6 □ Could not be	M 1 ☐ Yes 2 ☐ No
JIVISION OT al or Attending Ph s after death. I Director: After th ed in by the funeral	Certificate:	2 Accident Investigation	M 1 ☐ Yes 2 ☐ No
DIVISION OT lospital or Attending Ph 4 hours after death. uneral Director: After th ed filled in by the funeral		2 Accident 3 □ Suicide 4 □ Homicide 28e. Place of Injury - At home, farm, s building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	M 1 ☐ Yes 2 ☐ No treet, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)
the Hospital or Attending Ph fin 24 hours after death, the Funeral Director: After th mpletted filled in by the funeral	Medical Certificate:	29a. Certifier (Check only one) 27 Accident Could not be determined Certifying Physician: To the best of my knowledge, death only one) Certifying Nurse Practioner. To the best of my knowledge	M 1 ☐ Yes 2 ☐ No treet, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)
To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as t		29a. Certifier (Check Investigation Could not be determined Check Check Check Check Check Check Check Check Could not be determined Could not be det	M 1 ☐ Yes 2 ☐ No treet, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2ccured at the time, date and place, and due to the cause(s) and manner as stated.
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral		29a. Certifier (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death only one) 3 certifier	M 1
	Medical	29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type,	M 1 ☐ Yes 2 ☐ No treet, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 occurred at the time, date and place, and due to the cause(s) and manner as stated. 1 stigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 1 death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed Month, Day, Vear) Print
To the Hospital or Attending Physician Confidence of the Funeral Director: Afforth completed filled in by the funeral	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, death (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge death (Specify) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type,	M 1 ☐ Yes 2 ☐ No treet, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 occurred at the time, date and place, and due to the cause(s) and manner as stated. 1 stigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 1 death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed Month, Day, Vear) Print

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 102000 M James Η. Pleasant Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death Baltimore Washington Medical Center Glen Burnie nne 5. Social Security Number 6. Sex . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1930 North 1 ▼ M 2 □ F Months Hours Min (Month, Day, 79 240-34-6891 **Director** Carolina 16. Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel MD Glen Burnie 1 🗆 Yes 2 🙀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 215 Ridgely Road 21061 USA 12. Was Decedent Ever in U.S. Armed Forces? 1950-13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ^{2 No} 1954 Completed by Black, White, etc 1 Never Married 2 Married 1 X Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 X Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Sales Insurance 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Henry Pleasant Nora Parrish 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Jayne Pleasant/ Daughter 480 Colonial Ridge Lane Arnold, MD 21012 20a. Method of Disposition 20b. Place of Disposition (Name of November 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Meadowridge Memorial Park Elkridge, MD 2010 21. Signature of Funeral Service Licenses Bar 495 rranco & Sons, P.A. Severna Park Funeral Home Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to (or as a consequence of) cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy 5 Other (specify) Pregnant at time of death Month signed by the a Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has i autopsy certificate ☐ Yes 2 No 1 🗌 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ပ္ 1 Yes 2 No ER/Outpatient 3 DOA 1 Unpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending n 24 hours after death.

le Funeral Director: At pleted filled in by the fu 2 No Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 ho
To the Fune (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature nd title of cert .Date signed (Month, Day, Year) 2D 10 H 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month

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			1 - State of M Registrar	aryland / I		ment of H ficate of L		Mental Hy	giene Reg. No.	010	36838	
	Physic /Medi		1. Decedent's Name (First, Middle, Last) Eulalia Virgin	nia Pau	ıgh			2. Date of De Month	Day	010	3. Time of Death 6:33 A M	
La	Examii		4a. Facility Name (If not institution, give street and number) Garrett County Memoria 5. Social Security Number 6. Sex 7. Ac		oital		Location of Dea	ath	Ga	unty of Death	(0)	
	Funeral Director		232-62-0505 1 M 2 M F Usual Residence of Decedent	96	Yrs.	onths Days	Hours Mir	(Month, Da	71914	Con	place (State or Foreign htry)	
	be filed within 72 hours after death with the Maryland nat Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Exart ingransial be nettled at	Director	10a. State 10b. County WV Tucker 10e. Street and Number	10c. City, Tow	Thon				10a. Citizer	of What Cour	0d. Inside City Limits 1 ☐ Yes 2 No	
	death with	Funeral D	HC 60 Box 138 11. Marital Status 12. Was Decedent	Ever in U.S.	13. Was	2629 Decedent of Hi		Specify Yes or No	USA			
9600	nours after uraf", or ite	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced Armed Forces? 1 ☐ Yes, Give Ye ar or Dates:			s, specify Cuba Yes 2 ∏X No	n, Mexican, Pue	rto Ricán, etc.)		Black, White, ecify: Whi	etc.	
21215-0036	within 72 h ene. than "natu	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or \$	5+)	(Give kind life, DO	Decedent's Usual Occupation (Give kind of work done during most of working lifle. DO NOT use retired) S Station Owner		orking	Retail Ga		·	
and 2	tal Hygi I other	Be	17. Father's Name (First, Middle, Last)		13 01		18. Mother's Na	ime (First, Middle,	Maiden Sur		5	
Maryland	es 1 and 2 should be fi of Health and Mental I item 27 Is marked ot r other traumatic ever	ပ	19a. Informant's Name/Relationship (Type. Print) Clarence Paugh				and Number or F	Mae Wo Bural Route Number as, WV		_	Code)	
Baltimore,	~~ = ō		20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	20b. Place of cemete.	of Disposition Pry, cremato	n (Name of ery or other place	e)	Date /16/10	20c. Locati	ion - City or To	_	
Balti	permit. Page Department Important: Il any Injury o		21. Signature of Funeral Service Licensee		2 7 11	mekan eddrer	ซก็ซีซิล1	Home,	Inc.	as, w		
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each list Immediate Cause (Final disease or condition resulting in death) a	d the death. Do ne. a consequence	othe	ne mode of dyin		ac or respiratory and			Approximate Interval Between onset and Death	
	xecuted and I-transit	Examiner	cause. Enter Underlying Cause (Disease or Injury that Initiated events c.	a consequence		- #	ar	I)/seask				
68760,	ifficate be executed g physician and as the burial-transit	ledical E	d.	a consequence (01).							
P.O. Box (The law requires that the death certi ate has been signed by the attending bage 2 should be detached for use a	ysician/Me	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death		topic pregnancy ner <i>(sp</i> ec <i>ify)</i>			23d.	Date of delive	ry Day Year
ords, P.	law requires that nas been signed b 2 Should be deta	þ	Part II. Other significant conditions contributing to death by			lying cause give	n in Part I.	100		er.	e cause of death?	
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<u> </u>	iysicla iis cert directo	To Be	examiner?	ent 2 🗆 ER/Ou	itnationt 3	Other		ath <i>(Check only or</i> Home 5 ☐ Resid		Oth (0		
Division of Vital Records,	ittending Ph death. :tor: After th / the funeral	Certification: T	27. Manner of Death Natural 5 Pending (Month, Day 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Inju	ry 28b. T	Time of njury	28c. Injury Work? VI 1 □ Y		28d. Describe h	ow injury oc	curred		
ō	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	edical Cert	29a. Certifier (Check only (2) Medical Examiner: On the basis of	of my knowledge f examination an	e, death oco	curred at the time	e, date and plac	e, and due to the curred at the time, of	rallea(e) and	d manner as st	ated. the cause(s)	
	To the within ? To the comple	Med	29b. Signature and title of certifier	red.		29c. License	number			gned (Month, L		
	10	-	30. Name and address of person who completed cause of de	eath (Item 23a) (Type Print				1,	-		

State Registrar

Robert A. Goralski, MD 311 N.\$th St. Oakland, MD 21550

31. Date filed (Month, Day, Year)

NOV 23 2010

32. Fiegistrar's Signature

A. Aparl

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36839 State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 November Ida Mae Potter 1145 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Laurelwood Care Center E1kton Ceci1 Social Security Number Age (In vrs. last birthday If Under 1 Year I If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕅 F Months Hours Min. (Month, Day, April 15 New York Director 215-34-2074 Usual Residence of Decedent show 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 X No Maryland Cecil E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 167 Marley Road 21921 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 □ Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Mental Hygiene. arked other than Elementary/Seconday (0-12) College (1-4 or 5+) Cleaning Lady Cleaning Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Wesley C. Rose Lillian Ellen Johnson t. Page 1 and 2 should b rtment of Health and Mer rtant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Butler Potter/Brother-in-law 131 Marley Road, Elkton, MD 21921 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other i 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State The Church of Christ Cemetery November 4 Donation 5 Other (Specify) 2010 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hicks Home for Funerals, 103 W. Stockton Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death hysician. disease or condition resulting in death) Medical Examiner Malnutation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year 5 Other (specify) Pregnant at time of death Month Day signed by the 1 ☐ Yes ∠,≖ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has funeral director, page 2 autopsy performed death? ☐ Yes 2 2 N 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: ျပ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 Yes 2 🗌 No Investigation within 24 hours after death

To the Funeral Director. / Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

State

29a. Certifier

2 🗆

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

NOV

DHMH 17 Rev 7/2009

Registrar

Madhu S. Sachdev, M.D., 322 E. Cecil Avenue, North East, MD

el o

32. Registrar's Signature

eccu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

D0026183

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

November 15, 2010

21901

10-07553

Amend 4a per ME G909 11/23/10 dk Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Matthew Parks State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Medical Examiner 1630 hrs October 1, 2010 Matthew Albert Parks 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 45375 Woodland Drive 45375 Woodlawn Dr California St. Marv's 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Months Min Director Hours $_{1}X_{M}$ Country Maryland 2 F 215-36-4850 08/31/1939 Usual Residence of Decedent 'n 10a. State 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 X No 28a-f show Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once. Maryland St. Mary's California 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 45375 Woodlawn Drive United States 20619 Funeral 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? 1 X Never Married 2 Marrier White etc. 1X Yes 2 3 Widowed 4 Divorced If Yes, Give Year Yes 2 X No specify: Specify: White þ 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ 3 Graphic Artist Civil Service 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Sherman Albert Parks Ruth Bean 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores R. Lewis/Sister 21415 Williams Drive, Lexington Park, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Speci Brinsfield-Echols Cre 10/06/2010 Charlotte Hall, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Brinsfield. Iward N. Brinsfield, Jr. M00052 122955 Hollywood Road, Leonardtown Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear 20650 Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death a Atherosclerotic Cardiovascular Disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical UNPENDED AMENDED attending physician or use as the burial Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è 1 Yes 2 No 3 Probably 4 Unknown Completed has been page 2 should 24a Was an 24b Were autopsy findings available autopsy prior to completion of cause of death? performed? certificate ✓ Yes 2 No 1 🗸 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 DOA this 1 🗸 Yes 2 No After 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 1 🗸 Natural Director: Pending 1 Yes 2 No hours after death. 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City Could not be To the Funeral determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 Medical one) 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 2, 2010 onte 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar Signature State 9 70 Re Bon

Registra

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 State of Maryland /13/08/10 Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Ovember 5 Physician/ 0919 AM Nan V. Ray 2010 Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Rocky, 11 e Shady Grove Adventist Hospita montgomery If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F Hours (Month, Day, Washington, Director 86 Dec. Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland oortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director Maryland Montgomery Damascus 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 25124 Oak Drive 20872 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11 Marital Status 14. Race - American Indian Armed Force 1 Never Married 2 Married ☐ Yes 2 👿 No Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: If Yes, Give White 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) National Elementary/Seconday (0-12) College (1-4 or 5+) 12 Administrative Clerk Geographics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Edward L. Barnes Adeline Longstreet 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20872 Sharon A. Ray - Daughter 25000 Oak Drive, Damascus, Maryland Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematorium 11/7/10 Alexandria, Virginia 21. Sign ture of Fut eral Service Liceasee 22. Name and Address of Facility Molesworth—Williams P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Pulmonary Arrest disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying perkalenia the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical mellitus Diabetes Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant Pregnant at time of death Other (specify) this certificate has been signed by the raid director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 25. Was case referred to medical examiner?

1 Yes 2 No Be (funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c, Injury at work?
1 Yes 2 No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 \square Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 Vertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M. D. D0065505 5,2010 November of person who completed cause of death (Item 23a) (Type, Print) Qinfana Pockville, MD Medical Mar Dr 20 MD 9901

State Registrar 31. Date filed (Month, Day, Year

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amended #16a per State of Manyland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3 Day 2010 ar NOV. THERESA MARIE RIZZO 4:50P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 21001 SUGAR RIDGE TERRACE BOYDS MONTGOMERY If Under 1 Year If Under 24 Hrs. Funeral Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 DM 2 P 103-20-8956 Months Days Hours Min. Director 80 Usual Residence of Decedent ms 23a or 28a-f show must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MONTGOMERY MD BOYDS 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21001 SUGAR RIDGE TERRACE 20841 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Examiner 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No Specify: 3 🗌 Widowed 4 🗆 Divorced If Yes, Give Specify: WHITE Completed Year or Dates Medical 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) LEGAL SECRETARY SECRETARY event, the LAW FIRM 12 æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be I Department of Heaith and Menta Important: If item 27 is marked any injury or other traumatic ev GEORGE SCHOLTZ KATHERINE SULLIVAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20841 JAMES VINCENT RIZZO/SPOUSE 21001 SUGAR RIDGE TERR., BOYDS, MARŸĽĂŇĎ 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State RESTHAVEN CEMETERY 11/06/20/10 4 ☐ Donation 5 ☐ Other (Specify) FREDERICK, MD 21. Signature of Funeral Ser Licer 22. Name and Address of Facility P.O BOX 86 HILTON FUNERAL HOME BARNESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Dement disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death Unknown Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Dispase Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 24 hours after death.

Funeral Director: After this certificate I leted filled in by the funeral director, pag. 2 🗌 No 1 Yes 25. Was case referred to medica 8 26. Place of Death (Check only one) ē 1 🗆 Yes 21 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ■ Residence 6 □ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Acciden
☐ Sulcide Investigation 6 Could not be Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 11-4-2010 D60417

Registrar
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Name and address of person who completed cause of death (Item 23a) (Type, Print)

C

32. Registrar's Signature

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31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Eva Catherine Reunolds ovember 2010 920p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Fahrney-Keedy Nursing Home Washington Boonsboro 5. Social Security Number . Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 19 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Months Hours Min. Dountry) Maryland 214-32-2560 Director 94 1915 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits with the Maryland Examiner must be notified at Director 1 🗆 Yes 2 🔀 No Maryland Washington Smithsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 13139 Greensburg Road 21783 U.S.A.death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Completed by 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Machinist Knitting Company Be aryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Chauncey Calvin Miller Edith Elizabeth Weddle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13725 Frank's Run Rd. Smithsburg, Maryland 21783 Elise J. Wolfe (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗎 Removal from State 4 🗋 Donation 5 🦳 Other (Specifical November Smithsburg, Maryland Smithsburg Cemetery Donation 5 Dother (Specify) 18, 2010 Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Home MO1414 AVIS Bradbury Ave. Smithsburg, Maryland 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between ns and De h Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death 2 410 been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 \square Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy death? 1 ☐ Yes 2 ☐ No performed^a certificate I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2-No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident☐ Suicide Investigation 6 Could not be filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier сопрінь Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 031. W1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

10-08660		Please Type or Print in Black Indelible Ink. Ensure All Copi	es Are Leg		2011
Gary B. Slone	1	State of Maryland / Department of Health and Mental For State Certificate of Death		Second Co. Co.	36844
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Physician Medical Examine		Gary Bert Slone	Month November	Day Year 12, 2010	2136 hrs
10		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deal		4c. County of Death	
j		Anne Arundel Medical Center Annapolis		Anne Arundel	
Funeral		Months Days Hours Mi	-	h(MM/DD/YYYY) 9. Bir Foreig	n
Director	L	214-27-3401 1X M 2 F 25 Yrs.	Aug. 17	7, 1985	untryMaryland
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arylan arylan series	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Cour	ntry?
the M	5	1736 Waldorf Court 21114] ι	USA	
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other transmatic event, the Medical Examiner must be notified at once.	2	Gary A. Slone/ Father 4100 Yardley Court B			, _, _,
e, N l and 2 Health Item 2	ľ	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City or	Town, State
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Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo	
	-	O.C.M.E.		November 14, 2	
	-	30. Name and address of person who completed cause of death (Item 23a)			
Olo		Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201		
Sta		I MILLY ETD (ULU			
Registr	ar	person p. iguard			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36845 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2042 M Physician/ Month 30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis 9. Birthplace (State or Foreign Country) New Jersey If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number 6. Sex **Funeral** 3/25/1915 Months Min. 1 M 2 95 048-44-2184 Yrs **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🗓 No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 930 Astern Way, Apt. 306 21401 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 □ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ J. Roy Oliver Elsie Horner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol S. Gimmel/ Daughter 13528 Bonnie Dale Dr., Gaithersburg, MD 20878 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Physici Medi Exami

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

		1 ☐ Burial 2 【 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		Kalas	Crematory or other place)	11/1/1		-	, Maryland		
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Madical Carlificate: To	Medica	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
		29b. Signature and title of certifier 29c. License number 11/01/10									
		30. Name and address of person who	LRIEGE	th (Item 23a) (Ty	pe, Print) Y45 Det	Euse	they	Junay	rolis, MD		
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Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mildred Elizabeth Swick Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death WMHS-RMC Allegany Cumberland 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 WV 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** (Month, Day Sep 1 1 □ M 2 □x ^{Year} 928 Director 218-24-8437 82 Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "--- any injury or other than "---10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director MD Allegany Cumberland 1 □X√es 2 □ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21502 905 Braddock Road USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 Tes 2 No Specify: Specify: 3 Divorced 4 Divorced white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Post Office mail clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph Walker Moss Clara Mildred (Isner) Moss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
r 616 S. 7th Street Youngwood PA Julie Filicky 15697 Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Sunset Memorial Park 11/19/20/10 Cumberland MD 4 Donation 5 Other (Specify) 22. Name and Address of Furieral Home, PA 21. Signature of Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 23a. P. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List only one cause much line. Approximate Interval Between Immediate Cause (Final Physician/ Hip Fracture w/medical disease or condition Medical resulting in death) Due to (or as a consequence of): complications **Examiner** Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown 9 Unknown her significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 2 🗌 No Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 Hospital 1 X Yes Other: ၉ 1 Depatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 7 Natural 2 Accident 5 Pending Pt. fell in driveway 1 Yes 2 X No 5/24/2010 11:00AM after death Director: A I in by the f Investigation Suicide 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
905 Braddock Rd., Cumberland determined within 24 hours after
To the Funeral Direcompleted filled in b Residence Medical 1 Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier D31875 NOVEMBER 16 2010 DE SE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Snow MD Deputy Medical Examiner, 124 W 3rd St Cumberland 31. Date 10 Vor2, 31,2010 32. Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle Last) 2. Date of Death Physician/ REARE AZICIER ZU/U Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Tate Hospice House Linthicum Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 F (Month, Day OC 11 Months Days Min Director 191<u>7</u> 92 Maryland 215-16-7002 Dec Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Anne Arundel 1 Yes 2 X No Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4 Bunche St. 21401 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ੬ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2X No Specify: Black. Specify: 3X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 7th 0 Laundry U.S. Naval Academy Department injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles Holland Maggie Diggs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20721permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Marie Wilde(Daughter) 11607 Chantilly Lane Mitchellville, Md. Baltimore, 20a. Method of Disposition 2Malry1DamadonNato1ona1 20c. Location - City or Town, State 1 🎇 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Memorial Park Laurel, Md. 11-4-10 Windows Rames Research Scilit Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee H. Reese Zarr 100483 821 West St. Annapolis, Md. 21401 23a. Part 1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) ending physician and use as the burial-transi The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year 1 Yes 24 9 Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed2 2 🗌 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other:
4 Nursing Home 5 Residence 6 Other (She ဂ္ 1 Yes 2 ANO 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 24 hours after death.

Funeral Director: A 2 Accident
3 Suicide
4 Homicide 1 Yes 2 🗌 No Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 L 3 L To the within 2 To the F only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

NOV 0

Box 68760

P.O.

Division of Vital

Registrar's Signature

32,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician/ 201°ea November Mary Elizabeth Johnson Ward 8:15A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Casey House/Montgomery Hospice Montgomery Rockville If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🗔 🛪 Months Davs Hours (Month, Day, 97 215-72-8947 Director June Maryland Usual Residence of Decedent 'natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 23501 Woodfield Road 20882 U.S.A. 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc." Black, White, etc. þ 1 Never Married 2 Married 2 X No Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: White Completed 3X Widowed 4 □ Divorced event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Edgar Johnson Georgia Mae Cecil James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gaithersburg, Maryland 20882 Mary Ann Davis - Daughter 23700 Woodfield Road, other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. 1 Durial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) 11/12/10 Wesley Grove Cem. Gaithersburg, Maryland 21. Signature of Fun al Service 22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Septicemia Medical Due to (or as a consequence of): Examine Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of): law requires that the death certificate be executed use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? of Month Year 4 Pregnant Other (specify) Day Pregnant at time of death Yes 2 **X**No been signed by the a 1 ☐ Yes ≥ 1 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Small Bowel Obstruction 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Pneumonia , page 2 has autopsy Hospital or Attending Physician: The I 24 hours after death. Funeral Director: After this certificate h 2 X No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 XOther (Specify) Hospice Hospital: 1 Yes 2 XNo မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No X Natural injury 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Carein 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nicole Christenson CNP

NOV

DHMH 17 Rev 7/2009

32. Registrar's Signature

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

R120698

6001 Muncaster Mill Rd., Rockville, Maryland

29d. Date signed (Month. Day, Year)

November 4, 2010

20855

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ LINDA MAE WHEELER NOV. 15, 2010 Year 11:55A_M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death CLINTON 4c. County of Death
PRINCE GEORGES Examiner SOUTHERN MD. HOSPITAL Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 M 2 7 F 1/Morg/17Day1Y9147 577-62-3277 63 VA^{untry)} Director Usual Residence of Decedent 10b. County 10a. State with the Maryland aţ 10c. City, Town or Location 10d. Inside City Limits Director MD. CHARLES notified WHITE PLAINS 28a-f 1 🗆 Yes 2 🖁 No 10e Street and Number 6 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral items 23a 4015 CLYDE LANE 20695 U.S.A. · death v 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ō þ 1 Never Married 2X Married ☐ Yes 2 X No within 72 hours after Maryland 21215-0036 Specify.WHITE 1 ☐ Yes 2X No Specify. If Yes, Give Year or Dates "natural", Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) WASH. HEATING & ath and Mental Hygiene.
27 is marked other than r traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) COOLING, INC. TREASURER 12th Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည JAMES LEE SPROUSE DORIS ELIZABETH DEAL permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RONALD H. WHEELER-SPOUSE WHITE PLAINS, MD. 20695 4015 CLYDE LANE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State INITY MEM • GARDENS 11-19-10 WALDORF, MD. 4 ☐ Donation 5 ☐ Other (Specify) M00479 Signature of Funeral Service Licensee n 23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SEPSIS disease or condition Medical resulting in death) Dye to (or as a consequence of) Examiner 5 squentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ ģ Month Day Year Pregnant at time of death the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No this certificate 1 Yes 2 No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica burs after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 🗌 Yes 2 No Other: မ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending iniury Accident
Suicide
Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical

State Registrar 29a Certifier (Check

only one

3

who completed car

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

death (Item 23a) (Type, Print)

50

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year MARY IRENE WOLFE November 2010 2:05 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🛣 F Months Days Hours Min 217-10-0607 August 26. 90 Director Mary land Usual Residence of Decedent 10a. State 10b. County 28a-f sho 10c. City. Town or Location Examiner must be notified at 10d. Inside City Limits Director Frederick Maryland Frederick 1 Yes 2 No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 4912 Old Swimming Pool Road 21703 United States of America "natural", or items 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married þ ☐ Yes 2 🔀 No If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 A Widowed 4 Divorced White Specify: Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Seamstress Textiles Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည **Augustus Tyeryar** Flora Mae Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Sandra Fox / Daughter 6343 Yeagertown Road, New Market, Maryland 21774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State November 19. 1 A Burial 2 Cremation 3 Removal from State Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Mount Olivet Cemetery 2010 22 Name and Address of Facility **Keeney & Basford P.A. Funeral Home** 106 East Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Medical Examiner resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linju-that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of): nding physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy been signed by the should be detached ò Completed has page 2

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 this certificate within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral

with the

death

72 hours after

Page 1 and 2 should be filed

Baltimore, Maryland 21215-0036

Physicial	in the past 12 months? 1 ☐ Yes 2 🔀 No 9 ☐ Unknown	Month Day Year						
þ	Part II. Other significant conditions of OCALEY HTM	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown						
Completed		24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☐ No						
Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one)						
al Certificate: To E	1 ☐ Yes 2 🗷 No	ospital: 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA Other: 4 🗀 Nursing Home 5 🗀 Residence 6 🗀 Other (Specify)						
	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident Investigatio 3 □ Suicide 6 □ Could not be	28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? M	28d. Describe how injury occurred					
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
Medica	(Check 2 L Medical Exam	sician: To the best of my knowledge, death occured at the time, date and place, and d iner: On the basis of examination and/or investigation, in my opinion, death occurred at the se Practioner: To the best of my knowledge, death occurred at the time, date and place, a	e time, date and place, and due to the cause(s) and manner state					

29c. License number

MDD 65443

Frederick

29d. Date signed (Month. Day, Year)

MD

DHMH 17 Rev 7/2009

 \sum_{i}

State Registrar

29b. Signature and title of certifier

31. Date filed (Mont

ar KOVa

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

400

Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ Medical actity Name (if not institution, County of Death Examiner Ballimore . Age (In yrs. last birthday) 78 Yrs. If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Min **Director** Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits D ti more Yes 2 ☐ No 10e. Street and Number r items 23a or ner must be n ò 10f. Zip Code 10g. Citizen of What Country? Funeral 21229 Morle 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces Black, White, etc. ō þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. 2 **O**No Maryland 21215-0036 1 Yes 2 No Specify: "natural", Specify. Completed 3 Widowed 4 Divorced Slac the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working ife. DO NOT use retired) al Hygiene. I other than " College (1-4 or 5+) ye 1 and 2 should be filed wit tof Health and Mental Hygie If item 27 is marked other or other traumatic event, th Be ည OG Jenold Baltimore, 20b. Place of Disposition cemetery, cremator 20a. Method of Disposition Department of Important: If it any injury or o 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) re of Fune al Service Sia 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the moshock, or heart failure. List only one cause on gach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Due to (or as a consequence of Sequentially list conditions, Examiner if any, leading to immediate oduce. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Day Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops, performed? autopsy 1 Nes 2 No æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: မ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending within 24 hours after deam.

To the Funeral Director: Aft Accident 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in an action date. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and 29c. License number

Registrar

DHMH 17 Rev 7/2009

and address of person who completed cause of death (Item 23a) (Type, Print)

	/			For State Registrar	lease Type or State o		d / Depa	artment of I tificate of I	Health and			_	36852
è		Physicia Medic Examin	al	1. Decedent's Name (First, Manager 1) Catherin 4a. Facility Name (If not instit	e Mae Andr	nber)			r Location of Death	2. Date of Do Month	Pay 23 4c. C	3 Near	h
1		Funeral	÷	Franklin Sq1 5. Social Security Number 213-12-8205	uare Hospi	7. Age (In yrs. Ia 89		ROSE If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	rth BO	Altim g. Bir	thplace (State or Foreign untry) Maryland
a)		Director t show	ctor	Usual Residence of Deceder 10a. State 10b. Co	nt		, Town or Lo	cation Baltim	ore		-1321		10d. Inside City Limits
2 2		ith the Mar 23a or 28a- st be notifii	ral Director	10e. Street and Number 5501 Hamlet				10f. Zip Code	21214		10g. Citize	en of What Co	1 X Yes 2 □ No ountry? USA
catheri	5-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mertall Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Funeral	11. Marital Status 1 Never Married 2 3 Widowed 4 Divo	12. Was Dece Armed Fo 1 Yes	2 ဩ No ⁄e	ŀ	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (Span, Mexican, Puert	pecify Yes or No o Rican, etc.)		4. Race - Ame Black, White pecify:	
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Andrews	and	ld be filed Mental Hyg arked oth atic event	To Be	17. Father's Name <i>(First, Mid</i> Raymond S	_{ddle, Last)} tinson			_	18. Mother's Nar	_{ne (First, Middle} herine	, Maiden Su Warne		
X		and 2 should I Health and Me em 27 is marl ther traumati		19a. Informant's Name/Rela Catherine Jo			5501	g Address (Street A		Baltim	ore, M	Marylar	nd 21214
	altimore,	it. Page 1 artment of H rtment of H rtant: If ite njury or ot		4 Donation 5 Dot		Charles CE	enetery, cren eland	sition (Name of natory or other place Memorial	11-	Date 26-2010	Balt		Maryland
	Ba	permit. Departr Imports any injt		21. Signature of uneral Sen	A Muse	4.	Le	Name and Address	Ruck, I		Balti		rd Road MD 21214
	·	Vsician, Nedical Examiner	n i	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Separation of the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Due to (or as a consequence of): Control of the conditions of the cause (Final disease or injury). Due to (or as a consequence of): Control of the conditions of the cause (Final disease or injury).								Approximate Interval Between Onset and Death	
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). Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. The Funeral Sirector. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi	23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		come of pregnan Birth 2 Fetal nant at time of do nown	death 3	Ectopic pregnand Other (specify)	cy		23	3d. Date of de Month	livery Day Year
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	/ital	s certifi	To Be	25. Was case referred to med examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2 🗆 E	-B/Outnatien	Oth	er:	ok only one) Iome 5 \square Res	idence 6 [Other (Spec	(6.)
	ion of	eath. or: After this the funeral c	ficate: T		ending (Monsivestigation	of injury th, Day, Year)	28b. Time of injury	28c. Injury work M 1	y at	28d. Describe			
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(To t with To to		29b. Signature and tille of ce	Wel &	An	NEC	29c. License	6924	18	29d. Date	signed (Month	n, Day, Year)
4				DR. carrile	rson who completed caus Samiec	90001	Frani	klin Sq	uare Dr	. Balt	imor	re MD	. 21237
1		Stat Registra	e ir	31. Date filed (Month, Day, Ye NOV 2 9 2	010 Deneus	egistrar Signat	acke						
1	DHM	IH 17 Rev 7/20	09										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 201 n 9:00 PM Josephine Victoria Marshall Bravo November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Joseph Richey Hospice Baltimore n/a If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F May 18, 1920 90 New York Director 051-16-0309 Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Director Maryland n/a Baltimore 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 919 S. Charles St. 21230 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: than "natural", Specify: African American 3 X Widowed 4 Divorced Year or Dates. permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygene. Important If item 27 is marked other than "natur any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **5+** education teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Theresa Bradford Cyril Marshall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carla Bravo/daughter 919 S. Charles St. Baltimore, MD 21230 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Mary's Cemetery Nov. 30,2010 Yonkers, New York 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, 6500 York Rd. Baltimore, MD 2 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 JOSEPHINE BRAVO 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒️ No
9 ☐ Unknown Month Day Year Pregnant at time of death been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 → No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an cate has page 2 s 24 hours after death. Funeral Director: After this certificate Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 A No ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 \square Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 🗌 No Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 within 2 To the I only one 29b. Signature ar 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 82. Registrar's Signature State NOV 29 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36854 Certificate of Death nt's Name (First, Middle, Last) 2. Date of Death Physician/ Nonth. 22 10:30 AM 2010 Medical 4a. Facility Name If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2918 Brighton Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 248-32-9004 1 **2** M 2 □ F Months 84 Director Usual Residence of Decedent Department of Health and Mental Hygiene. Important, or items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any rigury or other traumatic event, the Medical Examiner must be notified at once. once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Funeral Director Baltimore MD1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Brighton 21216 12. Was Decedent Ever in U.S. Armed Forces?
1 ★ Yes 2 □ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🌠 No Specify: 3 Widowed 4 Divorced Black 15. Decedent's Education 16a, Decedent's Usual Occupation (Give kind of work done during most of working life, DO KOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Iruck . Be 18. Mother's Name (First, Middle, Maide ည Alberta Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street, and Number or Rural Route Number, City or Town, State, Zip Code) 2718 Brighton Street, Balfimore, MD Baltimore, 20b. Place of Disposition (Nam 20a. Method of Disposition Date Cemetery, crematory or other place) 1 Surial 2 Cremation 3 Removal from State 12-3-10 rrison 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hand failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ demontia End stage nears Medical resulting in death) Due to (or as a conse we nce of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): attending physician and for use as the burial-tran Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No ate has been signed by the atte page 2 should be detached for Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of autopsy death? To the Funeral Director, After this certificate I completed filled in by the funeral director, page 2 No of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA Certificate: To 4 ☐ Nursing Home 5 🛛 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. injury work? 1 ☐ Yes 2 ☐ No 5 Pending Division ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) DS1788 11-22-2010 M.O. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21209 Rd #300 Baltimore MD Falls POlk 6115 lim 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

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NOVEMBER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Maryla	nd / Depa Cer	rtment of F	lealth and				36855
			Registrar 1. Decedent's Name (First, Middle, Las	st)	OGI	incate or L	, cati	2. Date of De	Reg. N	10.	3. Time of Death
	Physicia		MICHAEL W.	BAYLOR				Month Novembe	ar S	24 2010	2100 M
	Medic Examin		4a. Facility Name (if not institution, give			4b. City, Town, or	Location of Deat			c. County of Deat	
		age and fire	SEASONS HOSPICE			RANDA	LLSTOWN			BALTIMO	ORE CO
	Funeral		5. Social Security Number 6. S	ex. 7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bir	th	9. Birt	thplace (State or Foreign untry)
	Director		220-66-1294 Usual Residence of Decedent	- W 2 - 1	54 Yrs.			NOV. 12	2 19	956 MAI	RYĹAND
	ihow at	占	10a. State 10b. County	10c. C	ity, Town or Loc	ation					10d. Inside City Limits
	faryla 8a-f tified	Director	MARYLAND N/A		BAT.	TIMORE					1X Yes 2 □ No
	or 2		10e. Street and Number		DITI	10f. Zip Code			10g. (Citizen of What Co	untry?
	s 23a ust b	Funeral	401 OLD ORCHARD	RD.			21229			U.S.A.	
	item item		11. Marital Status	12. Was Decedent Ever in U Armed Forces?	I.S. 13. W	as Decedent of Hi Yes, specify Cuba	spanic Origin? (S n. Mexican. Puen	pecify Yes or No- to Rican, etc.)		14. Race - Ame Black, White	
36	after I", or kamii	l by	XX Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🕅 No If Yes, Give		☐ Yes 2 X No				Specify:BLAC	
8	atura cal E	etec	15. Decedent's E	Year or Dates.	16a Deced	ent's Usual Occupa	ation		105	Kind of Business	
15	an "n Medi	Completed	(Specify only highest grant Elementary/Seconday (0-12)	ade completed)	(Give k	ind of work done of NOT use retired)	luring most of wo	rking	100.	Killa of Busilless	industry
212	withir grene er th		12th grade	College (1-4 or 5+)	CL	ERK ASSI	STANT			BC/BS	
pu	filed al Hy d oth	Be c	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	Maide	n Surname)	
ylaı	ld be Ment arke	욘	PETER W. HUDLEY				PATRIC	IA ZORA	BAI	DEN	
Maryland 21215-0036	shou and is m		19a. Informant's Name/Relationship (7	ype, Print) Sister	19b. Mailin	Address (Street a	and Number or Ru	ıral Route Numbe	er, City	or Town, State, Zip	Code)
o`	and 2 Health im 27 ther t		Alveteus Zora Bay				ard Rd.,			Marylar	
lor	ge 1 at of H		20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐	Removal from State		atory or other plac	· !	Date		Location - City or	
Baltimore,	it. Pa		4 Donation 5 Other (Special	7		N MEM GR					MARYLAND
Ba	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injuy or other traumatic event, the Medical Examiner must be notified at once.		2). Sometime of Funeral Service Dices	ee	WÎ	LLIAM C 206 W NO	BROWN CC RTH AVEN	MMUNITY UE	FUN	NERAL HON	ME P.A.
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	ate be executed physician and the burial-transit	E Exa	that initiated events resulting in death) Last	Due to (or as a consec	quence of):						
09	certificate be nding physici use as the bu	dical		d							
Box 687	entifica ling p e as t	Me	IF FEMALE:	23c. If yes, outcome of pregn	oncu.						
×	ath ce attend for us	ian	23b. Was decedent pregnant in the past 12 months?	1 Live Birth 2 Fe	tal death 3 🗔	Ectopic pregnance Other (specify)	У		- 83	23d. Date of del Month	livery Day Year
Ã.	the 3	ysic	1 Yes 2 No 9 Unknown	9 Unknown	death 5 =	Other (specify)					
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<u>'8'</u>	rires t sign ld be	g b						1 🗆	Yes	2 🗆 No 3 🗆 Pi	robably 4 Unknown
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ξ	hysic his ce I dire	은	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐		3 DOA Othe	er: 4 🗌 Nursing I	lome 5 Resi	dence	6 Other Spec	Tent disjues
of	ing P	ate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work	?	28d. Describe l	now inju	ury occurred	
<u>io</u>	ttend death tor; A	ific	2 Accident Investigation 3 Suicide 6 Could not b				Yes 2 No				
Division of Vital Records,	To the Hospital or Attending Physician; The law requires that the death certifics within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as t	Certificate:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	fy)	et, factory, office		City or Tov		und Number or Rui te)	ral Houte Number,
	pspita hours ineral d fille	Medical		sician: To the best of my know							
	the H lin 24 he Fi plete	Mec	(Check 2 Medical Exam only one) 3 Certifying Nur	iner: On the basis of examinationse Practioner: To the best of r	on and/or investi ny knowledge, d	gation, in my opinic eath occurred at the	n, death occurred time, date and p	at the time, date a ace, and due to th	and plac ie cause	ce, and due to the de(s) and manner as	cause(s) and manner stated. stated.
	T F F F F F F F F F F F F F F F F F F F		29b. Signature and title of certifier	1. 4		29c. License		_		ate signed (Month	
			Alen W	un		0009	13075		"/	25/201	10
3			30. Name and address of person who	completed cause of death (Ite	m 23a) (Type, Pi	igt) Av	Suts &	202 1	74 1	125/201	NO 71709
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& DHM	ИН 17 Rev 7/20	009							_		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) NOV. 2010 Physician/ 20 9:50 A M Bradbury Mae Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Crofton Convalescent & Rehab Center Crofton If Under 1 Year If Under 24 Hrs.

Months Davs Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) 5. Social Security Number Funeral Jan. 19, 1914 1 M 2 X F Maryland 96 Director 214-07-5791 Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10b. County 10a. State death with the Maryland the Medical Examiner must be notified at Director 1 ☐ Yes 2 🛚 No Anne Arundel Crofton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō Funeral items 23a **HSA** 21114 1836 Crofton Parkway . Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give "natural", or δ 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 Specify: 1 ☐ Yes 2X No Specify: 3 X Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Litton Industries Radar Assembler 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file and Mental H ပ Carrie Stucky Bernard Clark 1 and 2 should be of Health and Meitem 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1836 Crofton Parkway, Crofton, MD William Foster - Son or other 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition permit. Page 1 a Department of H Important: If ite Cemetery crematory or other place Quantico National Burial 2 ☐ Cremation 3 ☐ Removal from State 11-30-2010 Triangle, VA injury o 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 22. Name and Address of Facility Mullins & Thompson Funeral permit. 21. Signature of Funeral Service Licensee any Service, Fredericksburg, Virginia Part | . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ meni Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner ndjo Vascular Distan burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last physician Physician/Medical The law requires that the death certificate be Box 68760 for use as the been signed by the attending should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Day in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 Yes Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops, performed 2 **X** page 2 s 2 🗆 No 1 Yes certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Division of Vital To the Hospital or Attending Physician: director, Be Other: 4 ♥ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 1 Yes this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred I hours after death. uneral Director: After the filled in by the funeral Certificate: work' 5 Pending Natural 2 🗌 No 1 Yes Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) and the of certif 29b. Signatu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day 2010 Physician/ Nov. Margaret F. Biedenback 26, 1:37 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death 2106 Creek Rd. Sparrows Point Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days | Hours | Min. | Sep. 24, 1941 5. Social Security Number . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M **X**X Months 220-38-7486 Director 69 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Owings Mills 1 Yes XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 28 Wengate Rd. 21117 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes XX No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: XX Widowed 4 Divorced Specify: White Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Norbert Keller, Miriam Frances Wolfarth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Struble / Daughter 5908 Melville Rd. Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cometer, crematory or other place)
All Saints Cemetery 11/29/10 XXBurial 2 Cremation 3 Removal from State Reisterstown, MD 4 Donation 5 Other (Specify) Signature Fyneral service Licens 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Betweer Onset and Death Immediate Cause (Final Ph, sician/ A disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter ordenying Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be execute been signed by the attending physician and should be detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Dav Year Yes 1 ☐ Yes ∠ L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has funeral director, page 2 s autopsy performed 2 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Stepsons ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No Accident within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 380 31. Date filed (Month Day, Year) State 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ MANSON 4-30 AM 010 Medical 4a. Facility Name (if not institution, give street and number, 4b. City Town, or Location of Death 4c. County of Death **Examiner** MmoRE If Under 2 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F 83 Months Hours Month, Day, Year Director 1927 permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. 10a. State 10b. County ty, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12 0 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status 14. Race - American Indian, Black, White þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No 3 Divorced Completed Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) conday (0-12) College (1-4 or 5+) Elementary/S Be 17. Father's Name (First, Middle Last) (First, Middle, Ma ျ 19a. Informant's Name/Relationship (Type, Print) Zip Code 19b. Mailing Address (Street and No 1016 Method of Disposition 20b. Place of Disposition (Name of Date 200 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other pi 4 Donation 5 Nother (Specify) En Com 21. Sign ature of Funeral Service Doenses any 23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician METASTATIC COLORECTAL CANCER YEARS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence ot) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 K No 3 Probably 4 Unknown 24 hours after death.

Funeral Director, After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 X No 1 🗌 Yes Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital 2 🖾 No ٥ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 29a. Certifier 🛚 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tj∱le of centifie 29d. Date signed (Month, Day, Year) 064931 NOVEMBER 26, 2010 MD

State Registrar

DHMH 17 Rev 7/2009

600 NORTH WOLFE STREET, BALTIMORE, MARYLAND 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DAVID COSGROVE,

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER 2010 BOND 12:45 A M JOAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HOSPICE TOWSON GILCHRIST 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 😾 F Months Days Hours Min AUG. I5. MARYLAND 73 1937 **Director** 215-34-7862 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified any once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 👿 No MARYLAND BALTIMORE PARKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8509 U.S.A. DEMPSTER CT., APT. C 21234 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black. White, etc. 1 Never Married 2XX Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) CATERER CATERING 9TH. GRADE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ **ELMER JENKINS** PULLEN GEORGIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13046 JEROME JAY DR. COCKEYSVILLE STEVEN BOND/ SON 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) PARKWOOD CEMETERY 11/29/2010 BALTIMORE 21. Signature of Funer I Service Licenses 22. Name and Address of Facility
MILLER—DIPPEL
6415 BELAIR R FUNERAL HOME. AD BALTIMORE 21206 ROAD 23a. Part 1. Enter the disease, shock, or heart failure complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest tonly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Blad Ph sician/ der (ancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examiner Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 Unknown Unknown Part II, **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 AProbably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy certificate ha 1 🗌 Yes 2 🗆 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) within 24 hours a

To the Funeral I

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) K125808 11-24-2010 ah comp 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		epartment of Health and Certificate of Death	Mental Hygie	-2010 3h	360		
	Physicia	n/	1. Decedent's Name (First, Middle, Last) CITRISTINE	₽.A.I	KER	2 Date of Death	3. Time of			
-	Medic Examir		4a. Facility Name (if not institution, give st		4b. City, Town, or Location of Dear		4c. County of Death	74 IVI		
1-1	Funeral	ajir	CITIZENS CAD 5. Social Security Number 6. Sex		FREDERICK av) If Under 1 Year If Under 24 Hrs	8. Date of Birth	9. Birthplace (State of	or Foreign		
	Director		<i>437-38-8618</i> 1 ☐ Usual Residence of Decedent	M 2 1 F 7. Age (In yrs. last birthd	Months Days Hours Min		1919 MUSSISSIPI	P/		
	yland f show ed at	tor	10a. State 10b. County MD FREDER	10c. City, Town o			10d. Inside Ci			
	with the Maryland \$ 23a or 28a-f sho ust be notified at	Direc	10e. Street and Number		10f. Zip Code	10a	. Citizen of What Country?	2 □ No		
	th with t ns 23a must be	Funeral Director	111 TWIN EAG		21702		USA			
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fu	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 Yes 2 No Specify: 	pecify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: BLACK			
21215-0036	72 hou an "natu Medica	mplet	15. Decedent's Educ (Specify only highest grade	completed) (G	ecedent's Usual Occupation live kind of work done during most of wo e. DO NOT use retired)	rking	b. Kind of Business Industry			
	d within lygiene. ther the nt, the I	To Be Cor	Elementary/Seconday (0-12)	College (1-4 or 5+)	omestic		RIVATE FAMILI	E 3		
lanc	I be file Iental H Irked of tic ever		17. Father's Name (First, Middle, Last) £1000 Barn	165		me (First, Middle, Maid Mc 60w.				
Maryland	2 should the and the standard trauma		19a. Informant's Name/Relationship (Type MONI QUE WILL	e, Print) 19b. N	Tailing Address (Street and Number or Ru			102		
	of Health of Health fitem 27		20a. Method of Disposition 1 Burial 2 Cremation 3 R	20b. Place of D	isposition (Name of crematory or other place)		c. Location - City or Town, State			
Baltimore,	permit. Page 1 and Department of Hea Important: If item any injury or other once,		4 ☐ Donation 5 ☐ Other (Specify) 21. Signatury of Funeral Service Licensee	FAIRVIE	W Com. Nazo, 2	1010 P	RED. MD.	7		
Ba	permit. Departr Imports any inji		My X. Roll	leis	22. Name and Address of Facility 6/	ST FLESTS	11Ch MO 21701			
	Physician Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Die to of a a consequence of): Sequentially list conditions, b.								
	uted Id ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or as a consequence of).						
	ate be executed ohysician and the burial-transit	al Ex	resulting in death) Last	Due to (or as a consequence of):						
8760	tificate be ng physici as the bu	Medical	IF FEMALE:					=		
Box 68.	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and ated filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Y	/ear		
, P.O.	es that the des signed by the s be detached i	ਨੂ	Part II. Other significant conditions cont	ributing to death but not resulting in th	ne underlying cause given in Part I.	23e. Did tobacc	2 No 3 Probably 4 U			
Records,	w require s been si should	Completed				24a. Was an	24b. Were autopsy findings a	ıvailable		
Rec	: The law cate has					autopsy performed 1 🗆 Yes 2	prior to completion of ca death? No 1 \sum Yes 2 No	ause of		
Vital	iysiclan: The iis certificate director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	spital: 1 ☐ Inpatient 2 ☐ ER/Outpa	26. Place of Death (Che		e 6 ☐ Other (Specify)			
n of	ding Ph h. After thi funeral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year) 28b. Time injury	e of 28c. Injury at work?	28d. Describe how in				
Division of Vital	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this, completed filled in by the funeral dir	Certificate	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	M 1 Yes 2 No	28f. Location (Street City or Town, St	and Number or Rural Route Numb	er,		
ā	spital o nours af neral Di i filled ir		29a. Certifier 1 Certifying Physici		ath occured at the time, date and place, a	Si				
	the Ho	Medical	(Check only one) 3 Certifying Nurse I	r: On the basis of examination and/or in	vestigation, in my opinion, death occurred ge, death occurred at the time, date and pl	at the time, date and place, and due to the cau	ace, and due to the cause(s) and mar se(s) and manner as stated.	nner stated.		
	5 ≥ 6 0		29b. Signature and fittle of certifier	aufmmm)	29c. License number D - / 397	29d.	Date signed (Month, Day, Year)			
		ľ	30. Name and address of person who com	preted cause of death (Item 23a) (Typ	e, Print) T 4m th French	RUN MO	21701			
	Stat	~	31. Date filed (Month, Day, Year)	62. Registrar's Signature	exter and the second		. , 0 (
/	Registra	r	MUA 5 8 YOUR	Kenne p. 19.	- (C) (C)					

68760 Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 2010 Dona1d James Bruce 7:57 АМ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1932 Inverton Rd. Baltimore Dunda1k Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Maryland 220-78-9413 1 🙀 M 2 🗆 F 05/27/1957 Director 53 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Dunda1k 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 1932 Inverton Rd. USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 X Married 1 Yes : 2 🔯 No 1 Yes 2 No Specify: 3 Divorced Completed Year or Dates. White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Long Shoreman Shipping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bruce Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Cynthia Bruce</u> (wife) Inverton Rd. Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Hilltop Service Corp. 11/22/2010 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Duda-Ruck Funeral Home of 7922 Wise Ave. Dundalk, MD. 21222 Dundalk, Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arteriosclerat Cardiovascular Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to hinnediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of, To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Day Pregnant at time of death Other (specify) 2 No 9 Unknown sate has been signed by the page 2 should be detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural injury 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

30. Name and address of person

31. Date filed (Month Day, Year)

29

MD

6 Trimble Hill CT. Luther ville, Md

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 4:49 AM Physician/ 2010 Arthur A. Beksinski Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner N/A Baltimore Union Memorial Hospital Birthplace (State or Foreign Country)
 Many land If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number **Funeral** Hours 03-07-1927 1 🔀 M 2 🗆 F Maryland 83 Director 218-16-0976 Usual Residence of Decedent 10d. Inside City Limits th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the M-dical Examiner must be notified at 10c. City, Town or Location 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State Director 1 🔀 Yes 2 🗌 No Baltimore N/A Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Completed by Funeral 21213 2418 Pelham Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces X Yes 2 No 1 Never Married 2 X Married 1 ☐ Yes 2 ☐XNo Specify: Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates WII 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Bethleham Steel Machinist 18. Mother's Name (First, Middle, Maiden Sumame) Be 17. Father's Name (First, Middle, Last) Katherine Waryasz ည Walter Beksinski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lutherville, Maryland 21093 1300 York Road Jeff Higdon - Nephew 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Baltimore, Maryland 11-30-2010 Holy Rosary Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility 5305 Harford Road 21. Signature of Funeral Service Lives Leonard J. Ruck, Inc. Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Aspiration Tecminal Physician/ disease or condition resulting in death) Due to (or as a consequence of) Medical rears **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) eurs ackinsonism To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the bunal-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Month Day Year in the past 12 months? Pregnant at time of death Yes 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: Hospital No No 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 1 Yes ဥ 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death Certificate: 5 Pending Natural Natural 1 Yes 2 No Investigation
6 Could not be Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 3 ☐ Suicide 4 ☐ Homicide determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier T24389 Mitra 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union memorial Hashemi, MD Mitra 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2010 9 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 7.05 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b_City, Town, or Location of Death 4c. County of Death Examiner TWE rith more If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Min. 1 □ M 2 F 8 Days Hours 8 Marylana Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ıral", or items 23a or 28a-f show Examiner must be notifled at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5 Brett Court Apt. 322 21221 United States Funeral . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 █️No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced "natural". Completed er than "natur the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+)

1 Year Elementary/Secondary (0-12) Banking Administrative 27 is marked other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Suprowicz Helen Popera ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Blazucki / Son Health gen 27 it 2601 Paralell Path Abingdon, Maryland 21009 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Rosary Cemetery 11/29/2010 Baltimore, Maryland 22. Name and Address of Facility David J. Weber Funeral Homes PA 21. Signature of Funeral Service License steway 401 S. Chester Street Baltimore, Maryland 21231 23a. Part1. Enter the disease, or complications that cour ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear/failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine 16 burial-tran Division or Vital Records, P.O. Box 68760, Physician/Medical the attending pl IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 ☐ Unknown page 2 should Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed death? 2□ No 1∐ Yes 2 🗆 M Hospital or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) this funeral Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After ! Natural Injury 5 Pending investigation 1 Tyes 2 🗆 No death. Director: 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide within 24 hours a To the Funeral I 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one, and manner stated. the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 Sulte 208 Towson MD 212cg cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed 101 32. Registrar's Signature 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

10-08972 David Butcher Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Pavid Butcher	1- For State Registrar	State of Maryland		tment of <i>ficate of</i>		d Mental		20 l	10 36861
Physician Medical Examine	1. Decedent's Name (First, Mic	David		Butch	er		2. Date of Dea Month November	th	3. Time of Death 1850 hrs
	4a. Facility Name (if not institu		,	4	b. City, Town, or Baltimore	Location of De		4c. County of I	Death
Funeral Director	5. Social Security Number 218-21-5493	6. Sex 7.	Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days			th (MM/DD/YYYY)	9. Birthplace (State or Foreign Country) MD
id bow any	Usual Residence of Decedent 10a. State 10b. Count MD Ba	y altimore	10c. City, To	own or Locati		ındalk			10d. Inside City Limits 1 Yes 2 X No
th the Maryland 23a or 28a-f show notified at once.	10e. Street and Number	D 1			10f. Zip Code		1	0g. Citizen of What	
72 hours after death with the Maryland n "natural", or items 23a or 28a-f she al Examiner must be notified at once loted by Ermaral Director		12. Was Decede			2122 Decedent of Hises, specify Cuban	panic Origin?	(Specify Yes or No erto Rican, etc.)	United S	American Indian, Black,
5-0036 ed within 72 hours after bygiene. other than "natural", the Medical Examiner.				during most of working life DO NOT use retired)				Specify:	White ness/Industry
21215-0036 July be filed within 72 hours a: Mental Hygiene. marked other than "natural ic event, the Medical Examin	12 Years 17. Father's Name (First, Midd			Pizza	Maker	18 Mother's Na	ame (First, Middle, I	Food It	ndustry
121 Id be fil Mental F narked event,	David P. H	utcher		10h Mailing		Ange	lina Aver	ella	Otata 77 (0-1-)
MD nd 2 shc alth and m 27 is aumati	19a. Informant's Name/Relationship (Type, Print) Mr. David P. Butcher (Father) 20a. Method of Disposition 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 1958 Church Road Dundalk, Maryland 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1958 Church Road Dundalk, Maryland								
Baltimore, MD 2 permit. Pages 1 and 2 shou Department of Health and M Important: If item 27 is in injury or other traumatic.	1 Bunal 2 X Cremati	Specify:	State cre	matory or oth	erplace) ervice C	orp. 1	1/29/2010	Towson	, Maryland
	21. Sig at e of Funeral Servi	E Keed		/9	22 Wise	Ave.	1 Home of Dundalk,	Marvland	21222
Physician /Medical Examiner	23a. Part I. Ent. the disease, failure. Linguid one cau immediate Cause (Final disea or condition resulting in death	se on each line. se a. <mark>Multiple Injuri</mark> e	es	o not enter th	e mode of dying,	such as cardia	ac or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and Death
,	Sequentially list conditions,	b							
ted Insit	if any, leading to immediate cause. Enter Underlying Caus (Disease or injury that initiated events resulting in death) Las	Due to (or as a co		=====					
0, e be executed ysician and burial - transit	d. UNPENDED AMENDED								
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial transcontinuated by Dhysician/Madical E	IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 L	the 1 Live birth	at time of death	2 Fet	al death 3 [er (Specify)	Ectopic pre	gnancy	23d. Date of de Month	elivery Day Year
signed by the signed by the detache		litions contributing to de	eath but not resu	ulting in the u	nderlying cause g	iven in Part I.			te to the cause of death? Probably 4 Unknown
of Vital Records, P.(g. Physician: The law requires tha ther this certificate has been signed meral director, page 2 should be det 7. To Re Commisted by							1 ✓ Yes	sy prio rmed? dea	re autopsy findings available or to completion of cause of ath? Yes 2 No
n of Vital I ding Physician: h, : After this certifi e funeral director,		Hospital: 1 / Inpa	atient 2 E	R/Outpatient		of Death (Che Other, Nu		Residence 6	Other:
ision of Attending Ph ar death. ector: After t by the funeral	27. Manner of Death 1 Natural 5 Pe	28a. Date of I (Month, Da NoV 22, 20 restigation	njury 20 Y,Year) 1	8b. Time of Ir 719 hrs		y at Work? ′es 2 ✔ No		now injury occurred otorcycle struck	
Div ospital or hours afte incral Div y filled in	129a Certifier	termined (Specify) L	ocal Street		t, factory, office b		or Town, S Guy Way and	tate) Lynch Road, Du	
Di To the Hospital owithin 24 hours a To the Funeral I completely filled	(Check only 1 Certifying one) 2 Medical Ex	Physician: To the best of carniner:On the basis of e and manner state	xamination and/	death occurr or investigati	ed at the time, da on, in my opinion,	te and place, death occurre	and due to the caus ed at the time, date	e(s) and manner as and place, and due	s stated. to the cause(s)
	29b. Signature and title of certification. 30. Name and address of personal control of the certification of the certification.	1 14	Control (Horn 23	NI)	29c. License O.C.N			29d. Date signed November 23	(Month, Day, Year) 3, 2010
	Zabiullah Ali, M.D.	Assistant Medical	Examiner	111 Peni	Street, Balti	more, MD	21201		
State Registra		32. Regis	trar Signatue	ENCE					

10-08883 Jill K. Bray Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Jili K. Bray		State of Maryland / Department 1- For State Registrar Certificate	of Health a of Death	ind Mental F		2010	3686			
Physic Medical Exar					2. Date of De	ath	3. Time of Death			
		4a. Facility Name (if not institution, give street and number)	4b. City, Town,	or Location of Deat		Day Year er 19, 2010	1523 hrs			
		Baltimore Washington Medical Center	Glen Burn			Anne Arunde				
Funera Directo		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 X F 47	Months Da	ear If Under 24Hr ays Hours Mir		irth(MM/DD/YYYY) 9. Bi	an			
, h		Usual Residence of Decedent	Yrs.		Uct.	12, 1963 _{Ca}	l'ifornia			
te Maryland or 28a-f show any	4	10a. State 10b. County 10c. City, Town or Loc	cation				10d. Inside City Limits			
aryianc 88-f sh	1	Maryland Anne Arundel Severn	10f. Zip Code			10g. Citizen of What Cou	1 Yes 2 X No			
the M. Sa or 2.	Director	706 Sycamore Leaf Rd.	21144			United State				
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. The street of the single and Mental Hygiene. The street of the than "natural", or items 23a to 28a-f sho or other tranmatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 X Married Armed Forces? 13. \ Armed Forces?	Was Decedent of F	lispanic Origin? (S an, Mexican, Puerto	pecify Yes or No	o- 14. Race - Amer	ican Indian, Black,			
her dea ", or it			Yes 2 N		Rican, etc.)	White, etc.				
iours at Latural	A	or Dates:	ent's Usual Occup	ation (Give kind of v	work done	Specify: W] 16b. Kind of Business/	nite			
36 in 72 h han "n Jical E	plete	Elementary/Secondary (0-12) College (1-4 or 5+)		fe. DO NOT use reti	ired)		,			
5-00; ed with lygiene other t	Completed	17. Father's Name (First, Middle, Last)	ting	18.Mother's Name	(First Middle	Marketing				
1215 lbe fill ental H arked	Be	Richard Eugene Kunz				Trexler				
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. Is marked other than umatic event, the Medica	6			eet and Number or F	Rural Route Nur	nber, City or Town, State				
Baltimore, MD 2 permit. Pages 1 and 2 shou Department of Health and N Important: If item 27 is injury or other traumatic		20a. Method of Disposition 20b. Place of Dispo	osition (Name of ce	e Leaf Rd.	, Seve	on, Maryland				
MOF Pages nent of ant: If		1 Burial 2 X Cremation 3 Removal from State crematory or Metro Crematory of Metro Crematory or Metro Crematory or Cremator		Inc. Nov 20	. 24,	Catonsvill	,			
Baltimore, permit. Pages 1 an Department of Hea important: If iter		The specific	_	20		Catonsvill	e, Maryland			
Physician		23a-Part I. Enter the disease, or complications that caused the death. Do not enter	21 Crain	Hwy., S.	E., Gle	ome, P.A. n Burnie, M				
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a, Pulmonary Thromboembolism	the mode of dying	, such as cardiac of	r respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death			
A		or condition resulting in death) Due to (or as a consequence of):					Bedari			
	Jer	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			· · · · · · · · · · · · · · · · · · ·					
	if any, leading to immediate couse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):									
recuted and transit										
60, ate be exe hysician e burial -	Medical	UNPENDED AMENDED								
6876 certificate rding phy	M/ue	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 F	etal death 3	Ectopic pregnar	acv.	23d. Date of delivery Month D	No.			
Box 6876 e death certificat the attending phy	sician/	1 Ves 2 No Ged Holmour 4 Pregnant at time of death 5 0	ther (Specify)			Month	ay Year			
the c	Phys	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause (given in Part I.	23e. Did tol	pacco use contribute to the	ne cause of death?			
ords, P.O. w requires that the second of the	ed by					2 ✓ No 3 Proba				
Division of Vital Records, also rate the law requires after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	Completed				24a. Was a autops		opsy findings available impletion of cause of			
℃ ⊢ 3 å l	Com			sest a	perform 1 Yes 2	ned? death?				
n of Vital Redding Physician: The h. After this certificate function director, page	Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No		of Death (Check or Other's Nursing						
of \ing Ph	다: 1	27. Manner of Death 28a. Date of Injury 28b. Time of		- I I I I I I I I I I I I I I I I I I I		Residence 6 Other:				
ivision lor Attendi after death. Director:	gi	Pending Accident Investigation		res 2 No						
Division of Vital pital or Attending Physician: ours after death. eral Director: After this certif filled in by the funeral director,	Certification:	3 Suicide 6 Could not be determined (Specify)	et, factory, office b	uilding, etc. 2	28f. Location (St or Town, Sta	reet and Number or Rura ate)	Route Number, City			
		4 Homicide (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occur	red at the time, da	ite and place, and d	ue to the cause	(s) and manner as stated				
To the Howithin 24 h	ledical	2 Medical Examiner: On the basis of examination and/or investigated and manner stated.	ion, in my opinion,	, death occurred at	the time, date a	nd place, and due to the	cause(s)			
	Σ	29b. Signature and title of certifier	29c. License			29d. Date signed (Monti				
	}	30. Name and address of person who completed cause of death (Item 23a)	O.C.N	VI. ⊑,		November 20, 201	U			
		Donna M. Vincenti, MD Assistant Medical Examiner 111	Penn Street,	Baltimore, MD	21201					
Sta Regist		31. Date filed (Month, Day, Year) NOV 2 9 2010 August 3. Registrer's Signature								

DHMH 17 Rev 1/2001 OCME 2006

10-08	833
Brian	Bovle

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

onan boyle		1- For State Registrar	waryiand / Depa Cen	tificate of D		na ivienta	30	20	0 3685
Physic		Decedent's Name (First, Middle,Last)					2. Date of Dea Month	eg. No. th Day Yea	3. Time of Death
Medical Exam	iner	Brian Boyle 4a. Facility Name (if not institution, give stre	ot and number	l dh	7. T		Novembe	r 18, 2010	0000 hrs
		Mercy Hospital	eet and number)		altimore	or Location of E		4c. County of	
Funeral Director		5. Social Security Number 6. Sex 122 M	7. Age (In yrs. la:		Under 1 Ye Months Da		Min.	th(MM/DD/YYYY 1, 1977	9. Birthplace (State or Foreign W
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, 1	Town or Location				· · · · · · · · · · · · · · · · · · ·	10d. Inside City Limi
* "		unk unk	unk						1 Yes 2
Maryla 28a-f d at ou	Director	10e. Street and Number		10	f. Zip Code		1	0g. Citizen of Wh	at Country?
ith the Maryland 23a or 28a-f sho notified at once.	Ξ	unk		ur				unk	
15-0036 Highen vithin 72 hours after death with the Maryland Hygiene. of other than "natural", or items 23a or 28a-f she, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 XX Never Married 2 Married 1 1 3 Widowed 4 Divorced if Ye	Was Decedent Ever in U.S Armed Forces? Yes 2 xx No	If Yes, s	pecify Cuba	an, Mexican, Pu	? (Specify Yes or No uerto Rican, etc.)	White	
nurs aft Itural" amine	d by	15. Decedent's Education (Specify only high	ates:	16a. Decedent's U	sual Occupa		d of work done	Specify: 16b. Kind of Bus	White siness/Industry
6 172 ho an "na cal Ex	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during most of	of working life	e. DO NOT use	e retired)		ŕ
003 within piene.	dwc	12		unk				unk	
21215-0036 uld be filed within 72 Mental Hygiene. marked other than '	Be C	17. Father's Name (First, Middle, Last) Daryl R. Boyle					lame (First, Middle, I ra Meyer	daiden Surname)	
21 hould nd Me is ma	To	19a. Informant's Name/Relationship (Type,	Print)				or Rural Route Nun		n, State, Zip Code)
e, MD and 2 sho lealth and item 27 is		Daryl R. Boyle 20a. Method of Disposition	20h Pl	5928 Sug ace of Disposition			reendale, Wi		City or Town, State
Baltimore, Department of He Important: If ite		1 Burial 2 XX Cremation 3 R		ematory or other p				200. Location -	City of Town, State
Baltimo permit. Page Department Important: injury or otl		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Bayı	view Cremat		No ss of Facility	ov 24, 2010	Baltimor	re, MD
Balt permit. Depart Import		K. Gregory Fink	M01148				e, P.A. 426	Crain Hwy	S., Glen Burnie,
Physician		23a. Part I. Enter the disease, or complication failure. List only one cause on each lin	ons that caused the death. De.	Do not enter the m	ode of dying	, such as cardi	ac or respiratory arre	est, shock, or hea	rt Approximate Interve Between Onset and
/Medical Examiner		Immediate Cause (Final disease a. Ti	ramadol Intox						Death
4		h	o (or as a consequence of):						
`\	ner	Sequentially list conditions, if any, leading to immediate Due to cause. Enter Underlying Cause	o (or as a consequence of):						
,	Examiner	(Disease or injury that initiated C	o (or as a consequence of):						
ecuted and transi	1	d							
760, icate be executed physician and the burial - transit	Medical		ENDED 10d per		7,28a	-f per	me g911 1	-20-11 v	7t
Division of Vital Records, P.O. Box 68760, To the Hospital or Attention Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	W/u	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	 If yes, outcome of pregna Live birth 	nncy 2 Fetal de	eath 3	Ectopic pre	egnancy	23d. Date of o	delivery Day Year
BOX 687 he death certific the attending p	sician/	4	Pregnant at time of deat					ł	,
by the cheft	Physi	Part II. Other significant conditions contri	Unknown	ulting in the under	vino cause	given in Part I.	23e. Did to	bacco use contrib	ute to the cause of death?
i, P.O.	2		•		,g	9.70.7.7.7			Probably 4 V Unknown
Division of Vital Records, ral or Attending Physician: The law requir is after death. al Director: After this certificate has been seled in by the funeral director, page 2 should the control of the funeral director, page 2 should the funeral director.	ompleted						24a. Was a		ere autopsy findings available
eco he law te has	dmc			-			autops perform 1 ✓ Yes 2	m <u>ed</u> ? de	for to completion of cause of eath?
ital Recision: The sectificate rector, page	O	25. Was case referred to medical			26.Place	e of Death (Che		. 100	Yes 2 No
Vit.	္ပါ	examiner? 1 ✓ Yes 2 No	I I I I Patient 2 V L	R/Outpatient 3	DOA	Other Nu	rsing Home 5 1	Residence 6	Other:
n of ding Pt After funeral			(Month, Day, Year)	8b. Time of Injury		ry at Work?	28d. Describe h	ow injury occurred	d
SiOl Atten r death ector: by the	cati	2 Accident Investigation	d 11–18–10 f			Yes 2 X No	unknow		
Divi	Certification:	Suicide Could not be	8e. Place of Injury - At hom (Specify) home 1 es	ss shelte	•	bullaing, etc.	or Town, St	ate)	or Rural Route Number, City
Hospi 24 hou Funer tely fil		30a Cortifica	the best of my knowledge,			ate and place,			e. Baltimore,
To the Howithin 24 h To the Fun completely	Medical	one) 2 Medical Examiner: On the	e basis of examination and	or investigation, in	n my opinion	n, death occurre	ed at the time, date a	nd place, and due	e to the cause(s)
- 250	Ž	29b. Signature and title of certifier			29c. Licens			29d. Date signed	(Month, Day, Year)
		Famel Struthery, M.	(1)		O.C.I	M.E. 		November 1	9, 2010
į	ſ	 Name and address of person who complete Pamela E. Southall, MD Ass 	eted cause of death (Item 23 istant Medical Exami	•	enn Stree	t, Baltimore	, MD 21201		
		31. Date filed (Month, Day, Year)	Registrar's Signature.			.,	., = 1201	-	
Regist	rar	NOV 29 2018	Server A.	fact!					
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		1 - State Registrar	a.o o	ai y iai i		rtificate of l			Reg. No.	2010	36867	
Dhucici	*	1. Decedent's Name (First, Middle, Last)						Month				
Physici /Medic		ANTHONY CUN		HAM			Landa (Dark	NOVEMBER 26, 2010 3				
Examin	er	4a. Facility Name (If not institution, give street JOHNS HOPKINS ISAL)		HENIC	GI CEN		Location of Death	4c. County of De			ıtn	
Funeral		5. Social Security Number 6. Sex	7. Ag		ast birthday)	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th	thplace (State or Foreign ountry)		
Director		212-44-7097 ^{1X) M}	2 F	(63 Yrs.	Months Days	Hours Will.	AUG 15	1947		ARYLAND	
and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	ocation					10d. Inside City Limits	
Mary L-f sho fied a	tor	MARYLAND N/A			RΔ	LTIMORE					TXXYes 2 □ No	
th the or 282 e noti	Director	10e. Street and Number				10f. Zip Code			10g. Citize	izen of What Country?		
ath wi	ral	5251 CEDGATE RD.		<u> </u>	0 140		206	i6. Van au 81a		S.A. 4. Race - Am	erican Indian	
ter de Items Iner n	Funeral	1 K Never Married 2 Married 1	/as Decedent rmed Forces? □Yes 2XX	No		Was Decedent of H If Yes, specify Cuba		Rican, etc.)		Black, Whi	te, etc.	
hours after death with the Maryland tural", or Items 23a or 28a-f show al Examiner must be notified at	by		Yes, Give ear or Dates:			1 ☐ Yes 2XXXNo	Specify:		5	Specify: BI	LACK	
72 hc "natu	Completed	15. Decedent's Educatio (Specify only highest grade con	n npleted)		(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of work	ring	16b. Kin	d of Business	s/Industry	
within ene. than he Me	dmc	Elementary/Secondary (0-12) C	college (1-4or 5	5+)	MANA		4)		FO	OD SEF	RVICE	
e filed Il Hygi other /ent, t	Be C	17. Father's Name (First, Middle, Last)					18. Mother's Nam	e (First, Middle				
Menta Menta arked atic ev	To E	SUTHERLAND J. CUN	NINGHAM	1				E MAE D				
12 sh h and 7 is m traum		19a. Informant's Name/Relationship (Type. F				ng Address (Street						
Healt Healt tem 2		Antoineya S. Harris 20a. Method of Disposition	on/Niec	20b. P		Richards sition (Name of matory or other place		<u>Baltimo</u> _{Date}	re, M	lary Lar ation - City o	nd 21207 r Town, State	
Pages nent of nt: If i		1 ABurial 2 □ Cremation 3 □ Remo 4 □ Donation 5 ☑ Other (Specify)	val from State		NG MEM		12-0	4-10	BALT	IMORE,	, MARYLAND	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Conse			2 W	2. Name and Addre	ss of Facility BROWN CO	MMUNITY	FUNE	RAL HO	OME P.A.	
20 E 29		23a. Part1. Enter the disease, or complication	elle	d the death	1	206 W NOF	RTH_AVENU	E			Approximate	
Discolation .		shock, or heart failure. List only one ca	use on each li	ne.				or respiratory t			Interval Between Opset and Death	
Physician /Medical		Immediate Cause (Final disease or condition resulting in death) A. RESPIRATORY TAILURE Due to (or as a consequence of):										
Examiner		Sequentially list conditions. b. —	PNEC		0 / 1 /						2 2445	
ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	uence of):							
executed n and ial-transit	Exan	that initiated events c resulting in death) Last	Due to (or as	a consequ	uence of):							
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The law requires that the death certificate are has been signed by the attending physoage 2 should be detached for use as the	Physician/Medical	in the past 12 months?	f yes, outcome I□Live birth I□Pregnant a	2 Feta	I death 3	□Ectopic pregnanc	у		2	3d. Date of do Month	Day Year	
that the de	hysic		Unknown									
es that gned b	by P	Part II. Other significant conditions contribu	iting to death b	out not resu	ulting in the u	ınderlying cause giv	en in Part I.				to the cause of death?	
w requires that been signed I											Probably 4 □Unknown	
e law has b	ompleted								s an opsy formed?	24b. Were a prior to death?	autopsy findings available completion of cause of	
ician: The certificate harector, page	e Co	25. Was case referred to medical					26. Place of Dea	th (Check only	2 ☑ No one)	1 □ Ye	es 2 No	
S S	OB	examiner? 1 Yes 2 No Hosp	ital: 1 🗹 Inpati	ent 2	ER/Outpatie	nt 3□ DOA Oth	ner: 4 Nursing H			i □Other (Sp	pecify)	
• 5 • • • • • • • • • • • • • • • • • • •	on: T	1 ☑Natural 5 ☐ Pending	8a. Date of Inju (Month, Da	ury ay Year)	28b. Time of Injury	Wor		28d. Describe	how injury	occurred		
Attending r death. ector: After by the funer	icati	2 Accident investigation 3 Suicide 6 Could not be	8e. Place of in	iurv - At ho	ome, farm, st	M 1 ☐	Yes 2□No	28f. Location	(Street and	d Number or i	Rural Route Number,	
all or A after Direct	Certification:	4 ☐ Homicide determined	building, e	tc. (Specif	y)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			own, State)			
To the Hospital or Attendition 24 hours after death. To the Funeral Director: All completely filled in by the fu		29a. Certifier 1 CertifyIng Physicia 2 Medical Examiner:	On the basis of	of examina	owledge, dea ation and/or i	th occurred at the ti	ime, date and place opinion, death occu	e, and due to the urred at the time	e cause(s) e, date and	and manner place, and d	as stated. ue to the cause(s)	
o the ithin 2 o the omplet	Medical	one) 29b. Signature and title of certifier	and manner st	iated.		29c. Licens	se number		29d. Date	e signed (Mo	nth, Day, Year)	
- s - ō		> Andreas S. la	K, 1	40		RES	-000		NOVE	HBER.	,26,2010	
		30. Name and address of person who compl	eted cause of	death (Iten	n 23a) (Type	, Print)	DAL ALM	um n	n,	10.0	,26,2010 HD 21224	
	ate.	ANOREAS S, BA	32. Regist	アリ rar's Signa	. 979 ature	U EASIEI	an men	UE, B	tL//h	IORE,	MU LIZZY	
St	ate	MOV 2 9 2010 /	. 6	han	Nel.							

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36868 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 2010 Physician/ MARION IFKOT :08 A Novem 1221 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 200011 25/01/20 westminster (arrol 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Maryland 6. Sex 7. Age (In vrs. last birthday) **Funeral** (Month, Day, ay 29 Months Days Hours Min. 1 ▼ M 2 □ F Yrs. Director 66 944 218-42-6888 Usual Residence of Decedent 28a-f show 10a, State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director the Medical Examiner must be notified Westminster Maryland Carroll 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21157 30 Locust Street U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 9 þ 1 Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Il Hygiene. College (1-4 or 5+) Advertising Salesman Kaeser & Blair traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 7 is marked ot ပ္ permit. Page 1 and 2 should be Milton Ciekot Helen Marie Malon 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4024 Herdsman Dr. Hampstead, MD. 21074 19a. Informant's Name/Relationship (Type, Print) David M. Ciekot 4024 Herdsman Dr. Hampstead, MD. of Health item 27 or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o ō 1 Burial 2X Cremation 3 Removal from State Faiths Crematory Dec. 1,2010 Manchester, MD 4 Donation 5 Other (Specify) 111 22. Name and Address of Facility Eckhardt Funeral Chapel P.A . Signature of Funeral Service Licenses j. Het Elles 3296 Charmil Dr. Manchester, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): Certificate: To Be Completed by Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Reno! 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 N 2 🗌 No 1 🗌 Yes 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 2 M No Other: 1 ☐ Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mover of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of completed filled in by the funeral (Month, Day, Year) 5 Pending Natural 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 20059943

Registrar

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31. Date filed (Month, Day NOV 292

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ber Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Deat tomewood mor 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (Ştate or Foreign 1 M 2 D F Days Hours Min Director Yrs Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, with the Maryland Examiner must be notified at Town or Location 10d. Inside City Limits Director more 1 Yes 2 No 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral SA items 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. ŏ Completed by 1 Never Married 2 Married 21215-0036 1 Yes 2 No If Yes, Give Year or Dates Specify "natural", 100 3 Widowed 4 Divorced traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working is marked other than life. DO NOT use retired) . Page 1 and 2 should be filed within ment of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) ည 19a_Informant's Name/Relationship (Type. 19b. Mailing Address (Street and Number or Rural Route Number, City or 27 permit. Page 1 and 2 Department of Heath Important: If item 27 any injury or other tr once. aic 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State crematory or other place) Burial 2 Cremation 3 Removal from State Baltemore Marylan 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DUTH 270 Fredhulten femore Maryland 2122 Pass 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ Accident Cerebrovascular steresia Medical resulting in death) Due to (or as a consequence of): Examiner Hypertension Un/Cnau. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury Mellitra victor our (cheter burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician Physician/Medical P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for 5 Other (specify) Month Day Year Pregnant at time of death be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown should peen . Were autopsy findings available prior to completion of cause of death? 24a. Was an , page 2 s After this certificate has autopsy perform 2 🗌 No 1 Tes Yes 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death (Check only one) Other: မ 1 Tes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 🗆 Yes 2 🗌 No after death Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 3 only one 29b. Signati 29c. License number 29d. Date signed (Month, Day, Year) D0059056 23/10 MO

Registrar

DHMH 17 Rev 7/2009

State

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Registrar's Signature

EUtow St

Suite 301

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21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

filed (Month, Day, Year)

NOV 29 2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2 Physician/ W. CURFMAN 2350 M 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Carroll Hospital Center Westminster Carroll If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) Nov. 18, 1 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days 1 X M 2 D F Director 62 212-52-7778 1948 Maryland Usual Residence of Decedent show and Mental Hyglene. Is marked other than "natural", or items 23a or 28a-f sho aumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 🗌 Yes 2 🔀 No Carroll Maryland New Windsor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1854 Wilt Rd. 21776 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give 3 🗆 Widowed 4 🗆 Divorced Specify: Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 <u>truck driver</u> transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. traumatic Paul William Curfman Ruth Coe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucinda J. Curfman/wife 1854 Wilt Rd. New Windsor, MD 21776 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 \square Burial 2 \boxtimes Cremation 3 \square Removal from State 4 ☐ Donation 5 ☐ Other (Specify) County Cremation 11/29/2010 Sykesville, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Hartzler Funeral Home atter 310 Church St. New Windsor, MD 21776 23a. Part 1. Enter the disease, or complications that seed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ATHEROSCLEROTIC CARDIOVASCULAR Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence or). Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CARDIOMEGALY (HISTORY OF HYPERTENSION) Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown ACUTE AND CHRONIC NECROTIZING CHOLECYSTITIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsv performed? ☐ Yes 2 ☐ No To Be 25. Was case referred to predical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After thi 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours af

To the Funeral Di

completed filled ir Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 On Hydrig Mursa Fractioner: To the best of my knowledge. Seath occurred at the time date and place, and due to the cause(s) and manner stated. (Check D0037359 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KRIS

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

MEMORIAL

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SHEKITKA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 11 20 Î o 7:15 Collins Charlene Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Kensington Nursing Home Kensington 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
PA 8. Date of Birth **Funeral** Days Hours Min Month, Day, 1 1 D M 2 52 F Director 67 196-36-2992 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director or 28a-f sh notified a Yes 2 No DC Washington 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? ms 23a or must be r Completed by Funeral 20009 1443 Clifton St. NW USA ral", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 🗷 Never Married 2 🗌 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give "natural" B1ack 3 Divorced Specify: Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) CDA Council 12th grade Program Specialist permit. Page 1 and 2 should be filed wind Department of Health and Mental Hygic Important: If item 27 is marked other any injury or other traumatic event Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မှ Carl Collins Pearl Elizabeth Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2200 Touchstone Ct. Silver Spring, MD 20904 Merline Childress/Niece 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 11/23/2010 Alexandria, VA 4 Donation 5 Other (Specify) Metropolitan Cremat. Si na ure of Juneral Service Licen 22. Name and Address of Facility Marshall-March Funeral Home 4217 9th St. NW Washington, DC 20011 23a Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician Coronary Artery Disease Medical resulting in death) Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death Month Year 2 X No 9 Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Diabetes Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 24 hours after death.

Funeral Director: After this certificate Yes 21 No 1 Tes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No 유 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 2 Accider
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I 3 only one)

State Registrar

DHMH 17 Rev 7/2009

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Redistrar's

Sandeep Sharma MD 743 Summer Walks Dr. Gaithersburg MD 20878

29c. License number

D0064624

29d. Date signed (Month, Day, Year)

11/18/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] State
 Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 22, Savage Corbin 2010 Richard 6:30 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Bel Air Joppa 909 Rosemont Drive 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Day, Yea 1 🔀 M 2 🗆 F Months Days Hours Min **Director** Massachusetts 030-30-4537 1943 67 Jan. Usual Residence of Decedent f show at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 No Joppa Bel Air MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 909 Rosemont Drive United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1

Yes 2 □ No Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", Year or Dates.1960-64 Specify. 3 Widowed 4 Divorced White or other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) General Motors Corp. Automotive 12 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Elizabeth Shea Roy Andrew Corbin and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Mrs. Barbara Corbin (Wife) Joppa, Maryland 909 Rosemont Drive Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/23/2010 Service Corpi ice L Signature Fund al S Duda-Ruck Funeral Home of Dundalk, 21222 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, proprincitions that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or regart failure. List only one cause on each line.

Immediate Cause (Final Interval Between Onset and Death Ph sician/ BLADDIER CANCER disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncerlying Examine Due to (or as a consequence of): Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown is been signed by the should be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Funeral Director: After this certificate has autopsy performed? Yes 2 No 2 🗆 No 1 Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: iniury Natural Accident 5 Pending Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 24 within 2 To the I only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) PHYSSCAAN つしけんのれん 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21014 121 0000 0000 State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 24, 2010 10:05 Αм Janice Marie Crusse Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore 9107 Avenue B Edgemere Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 08-I1-1938 1 □ M 2 X F **Director** 72 Maryland 219-40-9703 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Baltimore Edgemere 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21219 9107 Avenue B United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 XNo Black, White, etc. 1 \square Never Married 2 \square Married Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 🗓 No Specify: Specify: White 3 X Widowed 4 □ Divorced Year or Dates or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Produce Manager 8 vears Food Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) မ Joseph F. Becker Alice Corwin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7720 Heathers Lane Nottingham, Maryland 21236 <u>George F. Crusse (Son)</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of Important; If it any injury or o once. cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State Hilltop Service Corp 11/26/2010 Towson, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death engest Physician/ Medical Due to r as a consequence of): Examiner Covonary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transi Cause (Disease or iinjury that initiated even resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 24a. Was an Were autopsy findings available prior to completion of cause of cate has t page 2 s autopsy perform death? After this certificate funeral director, pag 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Tes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ esidence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No I Director: # Accident Investigation Suicide 6 Could not be ithin 24 hours after de the Funeral Directo Impleted filled in by tl 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the F

completed only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Magno nomas NOV 2 9 2010 31. Date filed (Month, Day, 32. Registrar's signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITEM# 18 per FH, G909, 11/29/2010, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year OSCPK 2010 6:40 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sa Ro in 0 are Hospita 00 -imore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 🖾 M 2 🗆 F Months Days Min. -42-Director Yrs. Ary /HOV) Usual Residence of Decedent 28a-f show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 10d. Inside City Limits 1 Tes 2 No More 10e. Street and Numb e angelis, Joseph Maryland 21215-0036 10f. Zip Code 10g. Citizen of What Country? Funeral 311 USA IDMIN 21162 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 No Specify: White 3 - Widowed 4 - Divorced Specify: Completed Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) AS tOR TRANSPORTATION lectrician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ျ and 2 should be Health and Menta 050 اربع Sadie Conave11 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sud ANO-DE ANGEL Baltimore, 20b. Place of Disposition (Name of cemetery, grematory or other place, 20a. Method of Disposition Date ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 11-29-2010 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens JOSEPL 263 23a. Part 1. Enter the disease conplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ist only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician disease or condition 10 n Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to jer as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit onari certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Day Pregnant at time of death Month Year 1 Yes 2 L 9 Unknown 2 No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?/
☐ Yes 2 ☑ No 25. Was case referred to medical examiner? å 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Matural Natural 5 Pending Accident 1 Tes 2 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of ce/fifier 29d. Date signed (Month, Day, Year) man RES 00000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARYAM SAEED MD 9000 FRANKIN SQUARE DRIVE Rosedale MD 21237 31. Date filed (Month, Day, Year, 32. Registrar's S State 2 9 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 338 A M Month Year Mary L. Davis Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE HOSPITAL GOOD SAMARITAN 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Month, Day, Year) 10-24-1937 1 🗆 M 2 🗶 F Director 223-50-7766 Usual Residence of Decedent 10a. State 10b. County 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f sl idical Examiner must be notified na XXYes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 921 Northhill Road 21218 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2XXNo Black, White, etc. 1 Never Married 2 Married 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: Black Specify: 3 Widowed 4 Divorced Year or Dates If item 27 is marked other than "natur or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade House Keeper Seista Motel Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Johnny Hubbard Maude Barksdale 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tracey DeGrafenreid-7635 Perrington Terrace Balto, MD 21234 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) King Memorial 11-29-10 Pk Randallstown, MD Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H East 1101 E. North Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death BILATERAL Physician THACAMIC INFARCTS disease or condition resulting in death) Medical Due to (or as a consequence of Examiner SEIZURES Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of) ed by the attending physician and detached for use as the burial-transit ACUTE ON CHRONIC RENAL FAILURE that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be HEART DISEASE Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death
Unknown Month Dav Year been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HMPERTENSION, CANCER OF BREAST 1 Yes 2 No 3 Probably 4 Unknown Completed AND OVARY, ANTI-SYNTHETASE SYNDROME 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform After this certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\) Other (Specify) 2 X No 1 🗌 Yes 2 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at injury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident after death 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined e Funeral I 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29c. License number 29d. Date signed (Month. Day, Year) MD RES 000 23/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE YADAV 5601 LOCHRAVEN BLUD MD 21239 NANDINI 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

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10-09020 Davon Tramayne				ible. 20 i 0	36876
		I- For State Certificate of Death Registrar	Reg	g. No.	3. Time of Death
Physician Medical Examin	-	1. Decedent's Name (First, Middle,Last) Davon Tramayne Douglas	Month November	Day Voor	0817 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Dea	ıth
		University Hospital Baltimore		NA	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 218 - 98 - 3245 IN Mark 2 F 28 Yrs. Months Days Hours Min	_	1 (MM/DD/YYYY) 9. B	irthplace (State or Foreign country)
*		Usual Residence of Decedent 10a State 10b, County 10c. City, Town or Location			10d. Inside City Limits
ow any					XX Yes 2 No
nih the Maryland 23a or 28a-f show s notified at once.	힑	MD NA Baltimore 10e. Street and Number 10f. Zip Code	10	g. Citizen of What Co	untry?
he Ma	Director	920 Bethune Road 21225		USA	
with t	ᅙ	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S			erican Indian, Black,
death or iter	Funeral	1 Yes 2 No	rican, etc.)	Specify: Am €	African
s after iral", niner	<u>S</u>	3 Widowed 4 Divorced If Yes, Sive Year or Dates: 1 Yes 2 No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of	work done	16b. Kind of Business	
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re, rand I and Treath	1	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State	Date	20c. Location - City of Arbutus	
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	or Town, St		Rural Route Number, City
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To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	at the time, date a	and place, and due to	the cause(s)
To To	¥.	29b. Signature and title of certifier 29c. License number		29d. Date signed (M	fonth, Day, Year)
		Carde Hallain O.C.M.E.		November 25, 2	2010
i)		 Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2120 	01		
Sta	te				
Registr		31. Date filed (Manny Pay, Year) 32. Registrar's Signature A. January			
DHMH 17 Rev 1/20	01	OGME ORIGINAL			

Please Type or Print in Black Indelible Inky Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 110 1 - For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Estelle Diegel 2: 10 PM November 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 14 Hilltop Place Catonsville Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🗆 M 2 🗓 F Months Days Hours Min. (Month, Day, Year) Country) 94 Director 216-07-9317 June Usual Residence of Decedent 3a or 28a-f show t be notified at 10b. County filed within 72 hours after death with the Maryland 10a, State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2XXNo MD Baltimore Catonsville 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? or items 23a c Funeral Hilltop Place 21228 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item le lical Examiner n 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2XXNo Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify. Specify: Completed 3 X Widowed 4 Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) event, the Homemaker Own Home 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ဂ္ John Riznow Anna D. Dydin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 Hilltop Place, Catonsville, Maryland 21228 Mr. Richard Diegel / son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Glen Haven Mem. Park 11/23/2010 Glen Burnie, Maryland . Signature of Funeral Service Licensee 22. Name and Address of Facility 1 2nd Ave, SW Glen Burnie, MD MO/357 Singleton Funeral & Cremation Services, 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death End-Stage Dementiq Immediate Cause (Final Ph_sician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to incrediate cause. Enter Underlying Physician/Medical Examiner Due to for sels consequence ory Cause (Disease or linjury that initiated events resulting in death) Last the attending physician and hed for use as the burial-transit Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the atte Pregnant at time of death Year 5 Other (specify) Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown peen : 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed 2 🗆 No 1 Yes Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 욘 1 Inpatient 2 ER/Outpatient 3 DOA after death.

Director: After this 5 Pesidence 6 Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 🗌 Yes 2 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Sky PNNMD 29d. Date signed (Month, Day, Year) 11/18/10 D0057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N.S. RAJA PAKH, M.P. 2835 Smith AV S-703-Q Baltimore, MD. 21209.

DHMH 17 Rev 7/2009

State

Registrar

NOV 2 9 2010

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Gordon Bennett Doyle, Jr. Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 9. Birthplace (State or Foreign Country)
Beulah, CO If Under 24 Hrs. **Funeral** 8. Date of Birth 1**√** M 2 □ F Min. 89 **Director** 242-28-5557 Usual Residence of Decedent Director 10a. State 10b. County 10c. City, Town or Location the Maryland 10d. Inside City Limits 28a-f MD Anne Arundel 1 Yes 2 YNo Glen Burnie 10e. Street and Numbe ō 10f, Zip Code 10g, Citizen of What Country? must be 23a Funeral 206 Somerset Bay Drive Apt 102 21061 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2XXNo Black, White, etc. ō by 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2XXXNo Specify: "natural", Specify: White 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Machinist Westinghouse is marked other aumatic event, the Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Gordon B. Doyle, Sr. Mary Amelia Knapp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Mrs. Mary Baise Doyle / Wife 206 Somerset Drive Apt. 102 Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Important: If it any injury or o cemetery, crematory or other place) 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 2010 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory Glen Burnie, MD 21. Signature of Funeral Service 22. Name and Address of Facility Singleton Funeral & Cremation Services, PA 1 2nd Ave SW Glen BUrnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury that initiated events Physician/Medical Exami attending physician and for use as the burial-transi resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth
Pregnant igned by the atte in the past 12 months? Pregnant at time of death 1 Yes 2 No 9 Unknown been signed by ontributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autonsy death? Director: After this certificate 2 No Yes 2 - No 1 Yes To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: 2 No 1 Yes Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 2 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and t leted cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 19^{Bay} 2010 2108 Denise Angela Duncan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital Montgomery Social Security Number If Under 1 Year If Under 24 Hrs Months Days Hours Min. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 😾 F (Month, Day, 1 Year) Country) Director 59 DC 1951 577-66-2370 Usual Residence of Decedent or items 23a or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoi ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ty⊡ Yes 2 □ No Mecklenburg NC <u>Charlotte</u> 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 9307 Crofton Springs Drive 28269 USA 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2X No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Covington Burling Legal Secretary <u>2vears</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 <u>Ulysses</u> Duncan Doris Pailen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sellman Rd Adelphi, MD 20783 <u>Kevin Duncan</u>/ <u>Brother</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of h
Important: If ite
any injury or ot 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Donation 5 Other (Specify) Glenwood Cemetery 11/29/2010 Washington, DC 21. Signature of Fureral Service Licensee 22. Name and Address of Facility Marshall-March Funeral Home |4217 9th St. NW Washington, DC 20011 23a. Pht 1. Enter the disease, or complications that caused hock, or heart failure. List only one cause on each line 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) STHM EAR Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi attending physician and that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Pregnant at time of death 9 Unknown ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsv perform death? 1 ☐ Yes 2 ☐ No 2 1 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examine? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 은 1 Inpatient 2 KER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) filled in by the funeral 27. Mann Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury ✓ Natural 5 \square Pending 1 Yes 2 No thours after death uneral Director: / Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) leted cause of death (Item 23a) (Type, Print) 30. Name and address of person who co 31. Date filed (Month, Day, Year) 10 NOV 2 9 2010 32. Registrar's State 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of M	arylan	d / Depa	artment of F	lealth a	nd Mental Hy	giene 201	0 36880			
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	Medic Examin		4a. Facility Name (if not institution, give				4b. City, Town, or			4c. County of Death				
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Ī	Funeral		Social Security Number 6. S	ex 7. Ag	e (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24 Hours		h 9. E	Sirthplace (State or Foreign			
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	or 28	늅	MD Balt:	imore			10f. Zip Code	Dunda	IK.	10g. Citizen of What Country?				
	with vith s 23a nst b	Funeral	2035 Bear Ridge	e Road Ap	t. 20	02		21222		United States				
	leath items er m	핊	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S		Vas Decedent of Hi	spanic Origin	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - An	nerican Indian,			
36	", or amin	þ	1 Never Married 2 X Married	1 Yes 2 X	No		Yes XXNo		Puerto Ficari, etc.)	Black, Wh				
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Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	입	Earl A. Marsha	a11				Be	rtha L. Car	npbell				
Jar	shou and is m raum		19a. Informant's Name/Relationship (T	ype, Print)					or Rural Route Numbe	•				
	and 2 s Health s tem 27 i		Michael D. Cook 20a. Method of Disposition	(Son)	Tag: B			ourt	Parkville,		21234			
altimore,	nt of l		1 Burial 2 X Cremation 3		ce	emetery, crem	sition (Name of atory or other place	· i	Date	20c. Location - City				
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	Physician/		shock, or heart failure ast only of Immediate Cause (Final disease or condition	Sus	be U	red (endre	- f	whyth	mias.	Interval Between Onset and Death			
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Division of Vital Records,	or Att	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc	ry - At hor (Specify)	ne, farm, stre	et, factory, office		28f. Location (S City or Tow	treet and Number or R n, State)	ural Route Number,			
ā	To the Hospital or Attending Physician: The law requires that the uwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.		29a. Certifier 1 Certifying Phys	Pician: To the hest of	my knowle	adde death o	courad at the time	data and pla	ace, and due to the cau	uno(o) and manner as a	tatad			
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	,		▶ M.D				D-	38	t>4	11-22-	-2010			
			30. Name and address of person who c	completed cause of de	ath (Item :	23a) (Type, Pr	int) CTRRN	BL	754 VP. M	D- 212	21.			
	Stat	e	31. Date filed (Month, Day, Year)	32. Registra	r's Signatu	ire	2100							
	Registra		MOV 2 9 2010	Emal B	10	wed								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Murrel Newby Diggs Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City. Town, or Location of Death Good Samaritan Hospital Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Birthpi-Country) VA **Funeral** Months Days Hours Min. Aug. 28,1930 215-24-8837 80 Yrs Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director MD Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or any nijury or other traumatic event, the Medical Examiner must be a once. Funeral 21206 5535 Plainfield Ave. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 29 / 1 / 53 - If Yes, Give Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2x No Specify: Specify:Black Maryland 21215-003 Completed 3 Widowed 4 Divorced Year or Dates 6 / 23 / 55 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Modern Trash Co. <u>10th</u> Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Paul Diggs Alice Newby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5535 Dorothy V. Diggs (wife) Plainfield Ave. Balto, Md. 21206 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ★ Burial 2 Cremation 3 Removal from State 2010 vet.cem2 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest OwingsMills,MD 21. Significe of Funeral Service Licensee Name and Address of Facility Scruggs Funeral Home reston St. Balto, Md. Calvin B. Preston 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Atheroscheotic coronary vascular disease Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami Diabet attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year 5 Other (specify) Pregnant at time of death 9 Unknown been signed by the should be detached 9 Unknown the Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy After this certificate 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1 Tes ျ ER/Outpatient 3 DOA 1 🗌 Inpatient 2🗶 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Deat Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred iniury Natural 5 Pending death. 2 🗌 No Accident Investigation completed filled in by the within 24 hours are deat To the Funeral Director 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0062735 November, 22, 2010 Name and address of person who completed cause of death (Item 23a) (Type, Print) och Raven Blvd, Batimore MD 31239 rnaJonna State Registrar NUA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Glendora Harman Engman 24 2010 3:40 pM Nov. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Lorien Nursing Home Mt. Airy Carroll | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | June 1, 1922 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign West 215-18-2937 88 Virginia Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10b. County Maryland Carroll Hampstead 1 ☐ Yes 2 ☐No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3820 Normandy Drive #1C 21074 U.S.A. 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: 3 XWidowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ira Franklin Harman Zina Cooper 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jan Engman - daughter 3820 Normandy Dr. #1C, Hampstead, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State New Lutheran Cem. Nov. 27,2010 Manchester, MD. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Eckhardt Funeral Chapel P.A 21. Signature of Funeral Service Licensee 3296 Charmil Dr. Manchester, MD. 21102 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final mos

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

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"natural", or items 23a or 28a-f shovidical Examiner must be notified at

the Medical

permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once.

death v

filed within 72 hours after

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 the Hospital or Attending Physician: The

completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
winn ray tubus area to easu. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29b. Signature and title of certifie

31. Date filed (Month, Day,

Sequentially list conditions, if any, is ading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to (or as a consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consec	wence off	ge Untim		88 ys
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome pf pregn 1 ☐Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	al death 3 □Ectopic			23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not res	ulting in the underlying	g cause given in Part I.		use contribute to the cause of death?
				24a. Was an autopsy performed?	24b. Were autopsy findings availab prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to medical examiner?			26. Place of De	eath (Check only one)	
1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□ I	DOA Other: 4 Nursing	Home 5 ☐ Residence	6 □Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ome, farm, street, fact	ory, office	28f. Location (Street a City or Town, State	nd Number or Rural Route Number, e)
29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	nysician: To the best of my kno miner: On the basis of examina	owledge, death occurre ation and/or investigati	ed at the time, date and pla on, in my opinion, death oc	ce, and due to the cause(s curred at the time, date an	s) and manner as stated. If place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Westminster,

Registrar

State

the

of death (Item 23a) (Type, Print)

back

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent Name (First, Middle, Last) 3. Time of Death Physician/ 615AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death SEASONS HOSPICE AT NORTHWEST HOSP. RANDALLSTOWN BALTIMORE 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 ¼ M 2 □ F Hours Min 8/31/1916 94 **Director** 215-01-1725 MD Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location notified at Director 28a-f 1√Yes 2 □ No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a o edical Examiner must be Funeral 7121 PARK HEIGHTS AVENUE #205 21215 USA . Page 1 and 2 should be filed within 72 hours after death virent of Health and Mental Hygiene.
tant, if item 27 is marked other than "natural", or items lury or other traumatic event, the Medical Examiner muiny or other traumatic event, the Medical Examiner muints or the second sections. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian Armed Force Black, White, etc. ş 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) SALES REAL ESTATE æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) EPSTEIN 2 ABRAHAM REBECCA TOBOKOF 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NANCY WERTHEIMER / DAUGHTER 1105 BRYN MAWR RD; BALTIMORE, MD 21210 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date 1 X Burial 2 Cremation 3 Removal from State OHEB SHALOM MEM.PK. 11/22/2010 4 Donation 5 Other (Specify) REISTERSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. . Signature of Funeral Serv 8900 REISTERSTOWN RD; BALTIMORE, MD 21208 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on ea Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions. Examine cause. Enter Underlying Due to for as a consequence cry Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): led by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Other (specify) Pregnant at time of death been signed by the should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? page 2 25. Was case referred to medical examiner? completed filled in by the funeral director, 26. Place of Death (Check only one) Be 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence After this 27. Manner of De th 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes Certificate: 28d. Describe how injury occurred Natural iniury 5 Pending 2 🗌 No Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) To the

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9 2010

Registrar's

Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month George Elvin Evans, Jr. ouember 2016 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE JUSEPH MEDICAL CENTER TOWSON 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1X M 2 | F Months Days Hours Min Jan. 23, Year 956 MacryTand 54 Director 219-62-0883 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Parkville MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21234 United States 8613 Black Oak Road death v 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2X No Black, White, etc. þ 1 Never Married 2XX Married 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give "natural" Specify: 3 Divorced 4 Divorced White Completed Year or Dates the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene.

is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Superior Trucking Co. 8 Years Truck Driver Be Page 1 and 2 should be filed ment of Health and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ George E. Evans, Sr. Martha L. Ahern 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State. Zip Code) 8613 Black Oak Road Parkville, MD 21234 permit. Page 1 and 2 st Department of Health a Important: If item 27 is (Wife) Donna J. Evans 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Gardens of Faith Cem. 11/27/2010 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) Entombmen ö Baltimore, Maryland injury 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 21222 Wise Ave. Dundalk, Maryland art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ RIGHT ITEMUTITOR AX disease or condition Medical resulting in death) Due to or as a consequence of): Examiner ENDARY TO HEPARIN DAGULAPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last OBSTRUCTIVE PULMONARY SUVERE CHRINIC Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ SOUTHE CARDIOMY OPATHY 2 No 3 Probably 4 Unknown Completed NON ST ELEVATI 24b. Were autopsy findings available prior to completion of cause of death? INFARCTION 24a. Was an autopsy performed? 1 Yes 2 No ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ 1 Tyes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) 2010 2403

Registrar

State

31. Date filed (Month, Day, Year) NOV 2 9 2010 OSLER

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32. Registrar's Signature

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 20 Yestor November 4-55 AM Charlotte A Fitzgibbons Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner ANNE BALTIMORE GIEN BURNIE WASHINGTON MEDICAL 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8, Date of Birth 9. Birthplace (State or Foreign Funeral Month, Day, 1 □ M 2XXF Months Days Hours Min Baltimore, MD Director 216-20-8649 85 Usual Residence of Decedent 10a State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel 1 Yes XX No Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 8001 Corkberry Lane Apt 504 21122 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes ※XX No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married filed within 72 hours after 1 ☐ Yes XX No Specify: Specify: White 3XXWidowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) f Health and Mental Hygiene. item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Maryland 21 Administrator D.M.V. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit, Page 1 and 2 should be Henry Donald Zimmerman Charlotte T. Cummings 19a. Informant's Name/Relationship (Type, Print) Brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other to Mr. Charles F. Zimmerman Baltimore, MD 21213 Cardenas Ave Baltimore. 20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 2010 Donation 5 Other (Specify) Baltimore, MD New Cathedral Cem. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation M01220 Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 Enter the dibease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? certificate 1 ☐ Yes 2 ☐ No Yes the Hospital or Attending Physician: in 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending Accident 1 Yes 2 No M Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 0 d address of person who completed cause of death (Item 23a) (Type, Print) Glev Burnie 201 H

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death 648PM Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Davs Hours Min Country) 1 M 2 😾 0691271955 55 MD Director 215-48-6826 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No OWINGS MILLS MD BALTIMORE 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 3742 BIRCHMERE COURT 21117 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 TNo Specify. Specify: Completed 3 Widowed 4 Divorced WHITE or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) SURGEON MEDICINE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 GOODMAN FISHEL DOROTHY ELLIOTT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3742 BIRCHMERE COURT, OWINGS MILLS, MD MICHAELA BARRON/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 XCremation 3 Removal from State HILLTOP SERVICE CORP. 11/26/2010 TOWSON, MD 4 ☐ Donation 5 ☐ Other (Specify) of Fungral Service 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Part 1-Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) HOS Other Hospital Other: 1 Yes 2**N**0 ၉ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No injury Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number ge and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Year A M Medical 4a. Facility Name (if hot institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5. Social Security Numb 7. Age (In vrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Months Days Hours Min. Director 51 164-44-4415 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1x Yes 2 □ No PA Blair Roaring Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 709 Spang Street U.S.A. 16673 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married 2 X No 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Vice President Midasco LLC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 Stanley J. Gresko Nellie P. Koplets 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy Gresko (Wife) Spang St., Roaring Spring, PA 16673 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/24/10 Dudley, PA 4 ☐ Donation 5 ☐ Other (Specify) Aue Marie Cem. 21. Signatur Fun 22. Name and Address of Facility Curtis A. Heath F.H. 510 Railroad Ave., Broad Top, PA 16621 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ a. hemorrhage.

Due to (or as a consequence of): Medical resulting in death) Examiner rombal ytic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Oppendice al Due to (or as a consequence of): that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ Live Birth 2 Fetal dea
□ Pregnant at time of death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year n signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 📈 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Yes 2 N 2 X No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: ြု 1 Yes 2 🗖 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending work 2 Accident
3 Suicide 1 Yes 2 🗌 No Investigation 24 hours after deat Funeral Director, Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and titl 29c. License number completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who 31. Date filed (Month, Day, 32. Registr State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death / 40 P M GROSS Physician/ LAW RENCE Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SECOURS HOSPITAL ALTIMORE Sex 1XXM 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months (Month, Day, SEPT 1 Hours Director 70 Yrs. MARYLAND 212-36-1815 1940 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits the Maryland the Medical Examiner must be notified at Director 1 X Yes 2 No BALTIMORE MARYLAND N/A 10f. Zip Code 10e. Street and Number ō 10g. Citizen of What Country? Funeral items 23a 1800 HOLLINS TERR. APT. 217E 21223 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "nother than any injury or other trans 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2XXNo Specify: 3 Widowed 4 XDivorced Specify: BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 9th grade CONSTRUCTION WHITING-TURNER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည ROY MYERS MARGARET GROSS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3600 Southern Avenue, Baltimore, Md., Damon Bowen/Brother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial ŽXX Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 11-24-10 BALTIMORE, MARYLAND 21. Signature of Funeral Service Lice 22. Name and Address of Facility
WILLIAM C BROWN COM
1206 W NORTH AVENUE COMMUNITY FUNERAL HOME P.A. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between SEAS 13 Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): FAILMAE NESPIROTORY ⁴ Examiner Ecquentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner SEVENE CANONIC OBSTRUCTIVE LUND attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ANTERY DISTASE STENTS PLACEMENT CONDINARY Completed 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown RENAZ INSUFFICIENCY; PULYCYSTIC CARONIC 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy RRUS TATE 14DNE4 death? _ Yes Hospital or Attending Physician: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 🗌 Yes 2 No 2 ☐ Accident 3 ☐ Suicide Investigation
Could not be hours after deat meral Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hou To the Fune completed fi (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier moghbel, mo 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) most you I'm State Registrar

10-08986
Vicki Lynn Grimm

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2 0 | 0 State of Maryland / Department of Health and Mental Hygiene

			1- For State Registrar	o or waryland	•	ficate of De		····		Reg. No.	
Ma			1. Decedent's Name (First, Middle,L						2. Date of Dea	ath	3. Time of Death
IVIE	edical Exam	ııne	Vicki Lynn G 4a. Facility Name (if not institution,	rimm		145 03	. T			r 23, 2010	1105 hrs
			575 Dunnings Drive	give street and number)			ity, Town, or Lo Sby	ocation of De	eatn	4c. County of Calvert	Death
	Funera			Sex 7. Age (In yrs. last	birthday) If L	Jnder 1 Year	If Under 24	Hrs. 8. Date of B	rth (MM/DD/YYYY)	Birthplace (State or Foreign
	Directo	i	189-50-3653	M 2∑F	49	Yrs. Mo	onths Days	Hours I	din	3/1961	Country)
	- A		Usual Residence of Decedent 10a, State 10b, County		- 0't. T.						
	T POW SI	١.	MD Calve		-	wn or Location					10d. Inside City Limits 1 Yes 2 No
	urylan 8a-f st 8t onc	Director	10e. Street and Number		Lus		Zip Code			log. Citizen of What	
	the M a or 2 tified		12617 Durang	beog c			20657			U.S.A.	. Godiniy.
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status	12. Was Decedent Ev	er in U.S.	13. Was Dece	edent of Hispa	nic Origin? (Specify Yes or No)- 14. Race - A	American Indian, Black,
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	15-C filed v Hygi d oth	ပ္တိ	17. Father's Name (First, Middle, La	•						Maiden Surname)	
	212 uld be Menta marke	To Be	Ellsworth A. 19a. Informant's Name/Relationship	Grimm (Type, Print)	- 1	19b Mailing Addre				Richter nber, City or Town,	State Zin Code)
	MD 21215-0036 at 2 should be filed within 7 th and Mental Hygiene. by 15 is marked other than umatic event, the Medica	-	Freda Pearl G							ville, P	
	re, l		20a. Method of Disposition 1 X Burial 2 Cremation 3		20b. Plac	e of Disposition (Natory or other pla	Name of cemet		Date	20c. Location - Ci	
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	Baltimore, permit. Pages I ar Department of Hes Important: If ite njury or other tr		21. Signature o r u eral Service Lic.				ınd Address of	_	111 Eas	t Green	Street
	Physician	_	23a. Part I. Enter the disease, or con	mications that caused the	death Do	Brool	ks F.H	I.	Connell	sville,	PA 15425
	/Medical		failure. List only one cause on o	each line.		e Cardio				est, snock, or neart	Approximate Interval Between Onset and Death
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	ox 687 sath certific attending p		23b. Was decedent pregnant in the past 12 months?	1 Live birth		2 Fetal deat	th 3 🔲	Ectopic pregi	nancy	Month	Day Year
	Box 68 death certif the attending ed for use as	Physician	1 Yes 2 No 9 Unknow	Pregnant at time	e of death	5 Other (Sp	pecify)			1	
	that the de detached f		Part II. Other significant conditions	contributing to death but	t not resulti	ing in the underlying	ng cause give	n in Part I.	23e. Did to	bacco use contribut	e to the cause of death?
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	f Vi Physi er this	ျ	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury	h	Outpatient 3	DOA Oth			Residence 6 🗸 C	other: Scene
	Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should	tion:	1 X Natural 5 Pending	(Month, Day, Year)	200	. Time of Injury	28c. Injury at	2 No	26d. Describe n	ow injury occurred	
	ViSion Atte	fica	2 Accident Investigat 3 Suicide 6 Could not	29a Diago of Injury	- At home,	farm, street, factor	ry, office build	ing, etc.	28f. Location (S	treet and Number or	Rural Route Number, City
	Divi	Certification:	4 Homicide determine						or Town, St		,
	Division of Vital Records, P.O. Box 68: To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 Certifying Physic	ian: To the best of my kno	wledge, de	eath occurred at th	ne time, date a	and place, an	d due to the cause	e(s) and manner as	stated.
_	To the To the Comp	Medical	29b. Signature and title of certifier	r:On the basis of examinat and manner stated.	tion and/or				at the time, date a		
			1 (a. lasta	. ^		25	9c. License nu O.C.M.E			November 24,	
		ŀ	30. Name and address of person who	completed cause of death	(Item 23a)			··			
		[Laron Locke MD. Assis	tant Medical Examir	. ,	1 Penn Stree	et, Baltimor	e, MD 212	201		
	St Regist	ate	NOV 2 9 2010	32. Registrar's Si	gnature	ale					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Mary Ann Gres	aow	1- For State Registrar	Stat	e of Maryla		partment of e <i>rtificate of</i>		and	Mental I	Hygiene	Pog Na	21-min -400, 3	0 3	689
Physic Medical Exan		1. Decedent's Nam		•					_	2. Date of D Month	Day	Vear		of Death
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Funera Directo		5. Social Security I				. last birthday)	If Under Months	1 Year Days	If Under 24H Hours M	in		WDD/YYYY) 9 Fo	. Birthplace (S preign Ma r Country)	itate or
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r death or ite	Funeral	1 Never Marrie		1 Yes	x2x No	If Y	es, specify (Cuban, N	Mexican, Puerl	to Rican, etc.)		White, et	c.	
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menlar Hygiene. Important: I fitem 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	BeC		Fauver	51)				18		e (First, Middle y Oat		n Surname)		
211 hould I nd Mer is mar	5	19a. Informant's Na	me/Relationship			19b. Mailing	Address (Street a	nd Number or	Rural Route N	umber, C	City or Town, St	ate, Zip Code	:)
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Examiner		Immediate Cause (F or condition resulting	Final disease a ng in death)	Due to (or as a c			Diazepm	, Mep	robamate,	Carisoprod	ol, Met	thadone)		Death
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Division tal or Attendin ts after death. al Director: A	Certification:	2 Accident 3 Suicide	Investigat 6 Could not	28a Place o		1408 hrs ome, farm, street,				28f. Location (Street ar	nd Number or F	Rural Route N	umber, City
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	29a. Certifier (Check only one) 2	Certifying Physic Medical Examine	ian: To the best or:On the basis of	f my knowledo examination ar	ge, death occurre nd/or investigatio	d at the time	e, date a	and place, and ath occurred a	due to the cau	se(s) and	d manner as st	ated.	
To wit	Mec	29b. Signature and ti		and manner state	ed			ense nu		, 5510		Date signed (M		ar)
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2		30. Namé and addres Melissa Bras		completed cause of ssistant Medic			on Circo	Dell'	more MD	24204				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12:05 PM GEORGE ENELOPE NOVEMBER 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** HORINS BAYVIEW BALTIMORE MEDICAL Security Number 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Days 5-7-1926 Months Country) 84 WV **Director** 220-12-6435 Usual Residence of Decedent or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Baltimore 1 ☐ Yes 2 No Baltimore MD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 21224 USA 7121 Eastbrook Ave. items death v 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Armed Forces? Black, White, etc. 0 1 Never Married 2 Married ≥ Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify: White "natural", Completed 3 X Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Irene Mostris Savas Vardavas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3600 Adams Drive, Silver Spring, MD 20902 Steven George - Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State tment of 1 KBurial 2 Cremation 3 Removal from State Important: If any injury or Oak Lawn Cemetery 12-2-10 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bradley-Ashton Funeral Home PA, 2134 Willow Spring Road, 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) RESPIRATORY 30 HOUR Medical Due to (or as a consequence of): Examiner 3WEEKS HEART FAILURE CONGESTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examin YEARS CARDIOMYOPETH Hospital or Attending Physician: The law requires that the death certificate be executed HYPERTROPHIC burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No ₫ Month Pregnant at time of death detached 1 ☐ Yes 2 ☐ Unknown g | Unknown s been signed by t should be detach Part <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown CANCER 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 page 2 s 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 \(\subseteq\) Nursing Home 5 \(\subseteq\) Residence 6 \(\subseteq\) Other (Specify) 2 No 1 Tes မ 1 Natient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending death. ☐ Accident Investigation 24 hours after deat Funeral Director: completed filled in by the 6 Could not be 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

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EASTERN

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AVENUE

BALTIMORE

NOVEMBER

MD

27

21224

2010

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STEVEN JELIADES

4940

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#21perFD.G910 12/2/2010 WS.

State of Maryland / Department of Health and Mental Hygiene)

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			1. Decedent's Name (First, Middle, La	est)					:	2. Date of De		ay Ye	ar	3. Time of Death
	Physici /Medic		Nancy Paule	tte Gasior	owski	Ĺ				11	20	5 1.	10	1010 A M
	Examin		4a. Facility Name (If not institution, gir	e street and number)		4b. C	City, Town, or	r Location	n of Death		40	c. County of E	Death	
وم			105 3rd Avenue,			160	Glen			D-1(D)		Anne A		
	Funeral Director	100.000	5. Social Security Number 212–48–2284 Usual Residence of Decedent			rs. Mon	ths Days	Hours		8. Date of Bi (Month, D 07/19	lay, Year	7)	Countr	nce (State or Foreign y) MD
	and	tor	10a. State 10b. County	10c. C	ity, Town	or Location							100	d. Inside City Limits
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	the r 28a	Director	10e. Street and Number				. Zip Code				10g. C	itizen of Wha	t Countr	y?
	3a o	<u>=</u>	105 3rd Avenue,	SE			21061	Ł				U.S	S.A.	
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Michael Experience must be neithed at once.	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No	U.S.	ł	ecedent of H specify Cuba s 2 No	lispanic C an, Mexic	Origin? (Spectan, Puerto R	ify Yes or Nican, etc.)	0-	14. Race - A Black, V		C.
93	ral", C	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1016	5 ZE110	Specif				Specify:		
21215-0036	72 h	ete	15. Decedent's E (Specify only highest gr	ducation ade co <i>mpleted)</i>	16a.	Decedent's l (Give kind of	Jsual Occup work done	ation during mo	ost of working	9	16b. I	Kind of Busine	ess/Indu	stry
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р П	illed v Hygie ther i	ပိ	17. Father's Name (First, Middle, Last)		Dead	CICIAI		ther's Name	(First, Middle	, Maide			063
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چ	should nark martin	Ĕ	19a. Informant's Name/Relationship		19b.	Mailing Add	ress (Street					or Town, Sta		Code)
Š	nd 2: alth a 27 is rrtrau		Mr. Frank Gasioro	wski / Husban	d l	.05 3r	d Aver	ue,	SE (Glen B	urui	ie, MD	21	061
re,	s 1 a of Hear item othe		20a. Method of Disposition	20b.	Place of	Disposition (Name of or other plac	e)	Da	te	20c. l	Location - City	or Tow	n, State
E	Page nent c int: If		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	I Removal from State					11/29	/2010	Ва	altimon	re,	MD
Baltimore, Maryland	permit. Departn Importa any Inju		21. Signature of Funeral Service Lice			22. Nam	e and Addres	ss of Fac	ility1 2nd	d Aven	ue S	SW Gle	en B	urnie, MD
<u></u>	89 E # 8		Mark A. Vancu	ra MO1357 per	DVR							on Serv		
	The law requires that the death certificate be executed XX ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit a B B B B	<u>.</u>	23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate		equence o	740e	mode of dyin	g, such a		76 CT	arrest,	ν	1	Approximate niterval Between Onset and Death
P.O. Box 68760,♥		Medical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):											
		Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death	3 ☐ Ectop 5 ☐ Other	oic pregnanc r (specify)	у				23d. Date of Month		y Day Year
ds, P	w requires that the d been signed by the should be detached	5	Part II. Other significant conditions	contributing to death but not re	sulting in	the underlying	ng cause give	en in Par	t I.			use contribut		cause of death?
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al Records,	rsician: The law s certificate has b lirector, page 2 sl	Completed								auto perf 1 □ Yes	ormed? 2 X N	prior deat	r to com th?	pletion of cause of ! □No
<u>=</u>	siciar certii recto	Be	25. Was case referred to medical examiner?	Hospital:	7 = 0/0 .		Othe	or.	ce of Death	11				
Division of Vital	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certified completely filled in by the funeral director, p	tion: To	1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Reside 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Work? 2 Accident 1 Yes 2 No No No No No No No								nce 6 ☐ Other (Specify) w injury occurred			
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			29a. Certifler (Check only one) 12 Certiflying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifler (Check only one) 12 Certiflying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifler (Check only one)											
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	3		30. Name and address of person who Iru & Kaplan, M.	D. 7845 Cakn	cod	Rd#3	soo Gh	en B	umie	, Md a	406	1		
ı	Sta	te ar	31. Date filed (Month, Pay Yay)	32. Registrar's Sign	nature	2. 1/2/								

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Date U. Month Physician/ **29** M 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Heart Homes of Bay Ridge Annapolis If Under 1 Year If Under 24 Hrs 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Funeral Hours Min. ocT. I3 Maryland 1923 Yrs 216-12-5519 87 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at Director 1 Yes 2 TNo Anne Arundel Maryland | Pasadena 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? Funeral 21122 U.S.A. 285 Eagle Hill Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces? 1 ☐ Yes 2 🛣 No Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes Give Completed 3 ₩ Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene, Elementary/Seconday (0-12) College (1-4 or 5+) 12 Railroad Worker Transportation permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, the Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Olive Beatrice Palmer Don L. Garrett, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD Eagle Hill Rd. Pasadena 21122 Gene H. Garrett/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Nov Date 1 Burial 2 Cremation 3 Removal from State 2010 Glen Burnie, MD Atlantic Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death intarction Immediate Cause (Final Physician/ muocard disease or condition Medical resulting in death) as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir Cause (Disease or iinjury that initiated events resulting in death) Last physician and sthe burial-trans Due to (or as a consequence of). Physician/Medical P.O. Box 68760 as attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Pregnant at time of death ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed to should be deta þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy certificate Yes Hospital or Attending Physician: **Division of Vital** 25. Was case referred to medical 1551514 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 6 Other (Specify) this : After this funeral of 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury Natural 5 Pending work?
1 Yes 2 No Accident
Suicide 24 hours after death. Funeral Director: Al neral Director: A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one 29b. Signat title of certifie 50

Registrar

State

30. Name and address of person why

31. Date filed (Month, Day, Year)

Hwy M. Versulle MD 21/08

completed cause of death (Item 23a) (Type,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10 stafe of Maryland Poppartine 20 Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death HAZEL **Physician** 19,2010 Nov. 1020p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Future Care Charles Village N/A Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🙀 F 212-24-7500 83 Director April 14,1927 NĆ Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location show 10d. Inside City Limits I is merked other then "natural", or items 23a or 28a-f shor traumatic event, the Medical Examinar must be nothed at N/A MD Basltimore Baltimore Director 1XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 110 N. Central Ave. #306 21202 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 \$ 1 ☐ Yes 2 No Specify: Black 3₺ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is merked other then any Injury or other traumatic event, Item. College (1-4or 5+) Health Dept. 12th 2yrs Nurses Aide 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jesse Pittman Blanche Webb ္က 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lerry Pittman/ Brother 5416 Parkside Pl. Baltimore, MD 21206 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Final Journey 11/30/2010 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, MD 22. Name and Address of Facility Beverly D. Cromartie F/S 21. Signature of Funeral Service Licensee 2700 Edmondson Ave. Balto., MD 21223 2 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death istronaly Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to introduce cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) I or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No autopsy performe 1 ☐Yes 2 🗷 No **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 □Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier 29b. Signature and title of certifier HYSICIAN 57543 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar REETINDER

31. Date filed (Month, Day, Year NOV 2 9 2010

SANDHU

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1940 W. BALTIMURE ST. BALTIMORE MD 21823

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1- State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 20 1 0 36895										
			Registrar 1. Decedent's Name (First, Middle, Last)		2. Date of E							
	Physicia Medi		NELSON SMITH HAUGHW	Month				o. Time of Death				
- 26	Examir	ner	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death Towson				4c. County of Death				
The same	Funeral		E 0 110 E 11	GILCHRIST HOSPICE CENTER				Date of Birth	Baltimore County			
	Director	ı	195-20-2525 1X M 2 □ F	457 14 0 7 5					Birth 9. Birthplace (State or Foreign Country) Pennsylvania			
	now at	١	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation							
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Director	Maryland Baltimore County	**	timore					10d. Inside City Limits 1 ☐ Yes 2X No		
		Ē	10e. Street and Number	Dar	10f. Zip Code			100	. Citizen of Wha			
		Funeral	6504 Maplewood Road		21	L212			US	A		
	r deat		11. Marital Status 12. Was Decedent E-Armed Forces?		 Was Decedent of Hispanic Origin? (Specify Yelf Yes, specify Cuban, Mexican, Puerto Rican, 1			res or No- n, etc.)	14. Race - American Indian, Black, White, etc.			
036	s after ral", o Exam	d by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗓 1 If Yes, Give Year or Dates.	No -					Specify: White			
5-0	"natur	plete	15. Decedent's Education (Specify only highest grade completed)	lent's Usual Occup		- () ;	16	16b. Kind of Business Industry				
121	thin 72 ine. than '	Completed	Elementary/Seconday (0-12) College (1-4 or 5-	O NOT use retired)					Astronopo Tuduntus			
d 2	ed wil Hygie other ent, th	Be	12 17. Father's Name (First, Middle, Last)	TILU	11ustrator		r'o Nama (Fin		Aerospace Industry			
ılan	2 should be filed within 72 ih and Mental Hygiene. 77 is marked other than "traumatic event, the Mec	은	Frederick Haughwou			hryn		Aiddle, Maiden Surname) Booth				
ſaŋ	should and N is ma auma	.57	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	g Address (Street a	and Number	or Rural Rou	ite Number, Cit	y or Town, State	e, Zip Code)		
e, r	and 2 Health em 27 ther t		Roy Nelson Haughwout (Son) 20a. Method of Disposition		Murdock R	Road,	Baltin	ore, M	aryland	21212		
nor	age 1 ent of lit. If it		1 ☐ Burial 2 X Cremation 3 ☐ Removal from State	20b. Place of Dispo cemetery, cren	natory or other place	e) 1	Date			y or Town, State e,Maryland		
Baltimore, Maryland 21215-0036	permit. P Departme Importar any injur		4 ☐ Donation 5 ☐ Other (Specify) 21. Signal In o Furi al Service of the service									
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Box 68	ath certific attending p	ian/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of 1 ☐ Live Birth 2	Ectopic pregnancy				23d. Date of delivery Month Day Year				
80	law requires that the death certificate be executed has been signed by the attending physician and 2.2 should be detached for use as the burial-transi	Physician/M	1	Other (specify)	'specify)							
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Division of	ath. r: Afte	Certificate:	1 ☑ Natural 5 ☐ Pending (Month, Day, 2 ☐ Accident Investigation	work? M 1 Ves 2 No			d. Describe how injury occurred					
NISI VISI	fter de irecto	ĕrţ	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury building, etc.	Eon i			Location (Street and Number or Rural Route Number, City or Town, State)					
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3	within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
<u>۽</u> ع	with:		29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anax Ceris Villenmental Letter N. Churles St., Sto. 4105 Baltimore, MD 24									11-24-10			
								ners,	South			
بر	State 31. Date filed-(Month, Day, Year) 32. Registrar's Signature									204		
	Registra	r	NOV 2 9 2010 Sunta	A. parks								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2:20pm M November 2010 <u>James D. Hertz</u> Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Baltimore 302 Cantata #104 Reisterstown Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Funeral (Month, Day, Year) Hours 1 🛛 M 2 🗆 F MD Yrs. Aug. 74 Director 215-32-6496 Usual Residence of Decedent 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2X No Reisterstown Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 21136 302 Cantata Court Apt. 104 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 X Yes 2 Black, White, etc. 1 Never Married 2 Married 2 No þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: If Yes, Give White 3 X Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Professional Driver Transportation Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Helen Virginia Rogers Marvin Dennard Hertz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sl Department of Health al Important: If item 27 is any injury or other trau Pastor Reisterstown, MD 21136 David Stenner 203 East Chatsworth Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ☐ Burial 2 X Cremation 3 ☐ Removal from State 11/29/10 Hampstead, MD Carroll Cremation 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road 362 Eline Funeral Home Reisterstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Atherosclarotic Onset and Death 11-16/1 Coloning Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ng physician and as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Cther (specify) Day in the past 12 months?
1 Yes 2 No Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown detached. the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s been signed to should be deta by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy page 2 s has performed? 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical ours after death.

eral Director: After this certific filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? 2 🗷 No Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA မ 1 Tyes 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital of within 24 hours a To the Funeral Completed filled in the Funeral Completed filled in the Funeral Completed filled in the Funeral Completed filled in the Funeral Completed filled in the Funeral Completed filled in the Funeral Completed filled in the Funeral Completed filled in the Funeral Completed filled in the Funeral Completed in the Funeral Comple Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier es J. Mon. 032882 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Contra Diss 114 Banner Rol- 66 Mois

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#11perFH, G912, 2/25/2011, WS

State of Maryland / Department of Health and Mental Hygiene) 36897 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Year Lucy Mae Harper 2:30 PM Medical 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Preston Street 2410 City Baltimore Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth
(Month, Day, Year)
3-15-1926 9. Birthplace (State or Foreign 257-32-5354 1 □ M 2XXF Months Days Hours Min. Country) Director 84 Yrs GΑ Usual Residence of Decedent permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MD 1X Yes 2 ☐ No na Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2410 E. Preston Street 21213 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. -XXNever Married 2 Married \$ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes ZXINO Specify: 3
Widowed 4 Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 6th grade Custodian City of Baltimore Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ပ George Stephens Cora Plummer 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Frances Jefferson</u> 2410 E Preston Baltimore, MD Baltimore, Street 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MD National Mem 11-29-10 Laurel, MD 21. Signature of Funeral Service License 22. Name and Address of Facility March East F/H Bernan Balto, MD 21202 1101 E. North Avenue 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Onset and Death advanced demention 1ears disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events the burial-transi and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 use as ttending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth
4 Pregnant
9 Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day Year ate has been signed by the page 2 should be detached Yes 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by hyperpura thy willish 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No after death.

Director: After this certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 2 No Certificate: To Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 4 CENT 110 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Holden Salphare Eastern laia Ave nth. 31. Date filed (Mo 32. Registrar's Sign State NOV Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death November Physician/ Year 2010 5:14 PM aine House Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HRUNde VVAShington Medical Center urnie 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🗓 F Months March 10 1945 Pennsylvania 65 Yrs. 189-36-1863 Director Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Tes 2 X No Jessup Anne Arundel Maryland 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral United States 7810 Clark Road, A12 20794 or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No ò 1 Never Married 2 Married Elaine Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: White 3 Widowed 4X Divorced Completed Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Automobile Dealer <u>Title Clerk</u> Be permit. Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Walter Bernard Tomski Wanda Elizabeth Cawthorn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryland 20794 Jack L. Carter/Companion 7810 Clark Road, Al2, Jessup, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date West Arundel November 24 201<u>0</u> 1 🗌 Burial 2 💢 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) rematory Odenton, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A. Will Ets M00672 1411 Annapolis Road, Odenton, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Shock Onset and Death Immediate Cause (Final Septic Ph sician/ disease or condition day Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Bowel Exami the burial-transit or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year 4 ☐ Pregnant at time of death g ☐ Unknown sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan performed? certificate 2 🗌 No 1 Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Tes 2 No 1X Inpatient 2 ER/Outpatient 3 DOA မှ this 27. Manner of Death completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 1 Natural 5 Pending work?
1 Yes 2 No 24 hours after death. Funeral Director: Al Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined To the Hospital Medical Excertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 [within 24 only one 29b. Signature and fittle 29c. License number person who completed cause of death (Item 23a) (Type, Print) 10

Registrar DHMH 17 Rev 7/2009

State

Burnie,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Nember Physician/ DO:US P.M. Norma Virginia Hutchinson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth **Funeral** 1 □ M 2 🌡 F 90 1071071920 218-01-4735 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturo" any injury or other traumatic events. 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Tes 2 No MT Anne Arundel Severn 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral 712 Dorol Court 21144 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. ģ 1 Never Married 2 Married Yes 2 XNo 1 Yes 2 No Specify: White Specify. If Yes, Give 3 X Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Plastics Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last မ Samue 1 Connelly Koch Anna 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 712 Dorol Court Severn, 21144 MD Deborah Ann Hutchinson 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 11/26/2010 4 ☐ Donation 5 ☐ Other (Specify) Brooklyn Park, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on part line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a nsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence off. signed by the attending physician and i be detached for use as the burial-transit Cause (Disease or linjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 N) 3 Probably 4 Unknown 1 Yes Completed page 2 should . Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has Yes 2 N 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA ၉ After this . Date of injury (Month, Day, Year) 27. Manner of De th 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending n 24 hours after death.

e Funeral Director: Afte losted filled in by the fun Investigation ☐ Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 x Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Tpleted 1 A leading in the least of my introduce, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

A leading least miner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

Name and addre

31. Date filed (Month, Day,

of pers

on who completed cause of death (Item 23a) (Type,

AMEND #36Ae BERMartia 6809 Debarra 640 of Health and Mental Hygien (Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 010 Year Nov 22 11:50P M Jacquelin Ann Hooper Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Carroll Westminster Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours Min. 1-23-1926 MA Country) 029-12-8386 84 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Carroll MD Westminster 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21158 201 St. Mark Way, Apt. 215 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or item ledical Examiner n Armed Forces? Black, White, etc. ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2x No Specify: SpecifyWhite 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' ury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Hpusewife HOUSEWIFE 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gay A. Thibeault Leola May 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Warren Hooper-son 1718 Peppermint Lane, Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place)
Emory Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot once, 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/27/10 Upperco,MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Fineral Service Licensee 22. Name and Address of Facility Fletcher Funeral Home hones 254 E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final PSIS Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 2 days reloneoha his Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Due to lor as a conse, uence of been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be execution 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician ar completed filled in by the funeral director, page 2 should be detached for use as the builath-th resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death 1 ☐ Yes 2 5 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Piballation 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 Yes 2 No Be (25. Was case referred to medical 26. Place of Death (Check only one) 2 🗖 No Hospital 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 1 🔲 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No injury 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis or examination almost investigation, in my opinion, obtained the state and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11/23/2010 1231660 Q 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WES MINISTER MANY AVENUR STONER THOM AS 31. Date filed (Month, Day, Year) Registrar's Signat Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of W	iaryianc		tificate of D	lealth and Death	•	Reg. No 0	10	36901
	Physicia		1. Decedent's Name (First, Middle Herbert F	. Hull, Jr.			•		2. Date of De	ath	010 ^{ar}	3. Time of Death 7:22 A M
	Medic Examin		4a. Facility Name (if not institution		<u>.</u>		4b. City, Town, or	Location of Deatl		4c. Coun	ty of Death	
	-	-	Gilchris 5. Social Security Number		ge (In yrs. las	at histholau)	Tows	on If Under 24 Hrs.	I o para at pire		timore	
	Funeral Director		218-14-9982	1 × M 2 □ F 8		Yrs.	Months Days	Hours Min.		, Year) 925	Mary	place (State or Foreign
	and show	tor	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	ation				1	0d. Inside City Limits
	Mary 28a-f notifie	Director	Maryland Balt	imore		Towson						1 ☐ Yes 2 🎇 No
	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	ral D	10e. Street and Number 8434 C Charle	es Valley Co	urt		10f. Zip Code 21204			10g. Citizen of		ntry?
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I fire Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status	12. Was Decedent E	Ever in U.S.		/as Decedent of His Yes, specify Cubar			14. Ra	ace - Americ	
036	rs after ral", or Exami	ed by	1 ☐ Never Married 2 🌠 Mar 3 ☐ Widowed 4 ☐ Divorced	If You Circo			☐ Yes 2 💢 No		, , , , , , , , ,	Specif	ack, White, of Wh	ite
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Maryland 21215-0036	be filed on the ked other ic event,	To Be	17. Father's Name (First, Middle, L	,	•				me (First, Middle,		ne)	
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Σ	nd 2 sk ealth a m 27 is er tra		Ruth V. Hull /	Wife	11		C Charles			Towson,		*
Jore	Page 1 al ment of H ant: If iter ury or oth		20a. Method of Disposition 1	3 Removal from State	cer	metery, crem	sition (Name of atory or other place		Date	20c. Location	•	
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<u>~</u>	Dec any		Val I	11/		R	uck Tows	n Funer		Inc. Tov	vson,M	ld.21204
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10	d d ansit	amin	of any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to for as a	a conseque	rice oij.						
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State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November J. John Hook Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Am Baltimore Baltimore Oak Crest 337, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral Months Days Hours (Month, Day, 1 X M 2 X F 915 Director 213-03-3263 11/22/10 28a-f shov 10b. County 10c. City, Town or Location 10a. State the Medical Examiner must be notified at Director Baltimore Md.Baltimore 10f. Zip Code 9 10e. Street and Numbe 10g. Citizen of What Country? 23a Funeral 21234 8820 Walther Blvd. #3205 items death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status John Was Decedent Ever Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates. Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Salesman Mill Supplies traumatic event, Be Department of Health and Mental High Important: If item 27 is marked oth any injury or other traumatic conce. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Delmar Elizabeth Henderson Charles Wallace Hook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8820 Walther Blvd. #3205 Baltimore, Md. 21234 Mrs. Doris S. Hook/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State 11-23-10 Towson, Md. 4 Donation 5 D Other (Specify) Hilltop Service Co. 22. Name and Address of Facility Ruck Towson Funeral Home, 21. Signature of Funcial Pervio York Rd. Towson, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph_sician/ Prostat disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to (or as a consequence of) If any, leading to Immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician; The law requires that the death certificate be executed physician and the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 4 Pregnant at time of death 9 Unknown 2 No. the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an certificate has autopsy page performed' 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) 2 **N**o Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 욘 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 🗆 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number anono MI-175567 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Perico ! (10 UM) 21234 Anne

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

3:37

9. Birthplace (State or Foreign

10d. Inside City Limits

Onset and Death

1 Yes 2X No

Mary land

White

USA

14 Race - American Indian

Black, White, etc.

23d. Date of delivery

1 Yes

Day

24b. Were autopsy findings available prior to completion of cause of death?

2 No

Year

Month

20**1**0

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

			Please	Type or Prir					•	·.	
			For State Registrar	State of Ma	aryland / Depa <i>Cer</i>	artment of I <i>tificate of I</i>			ene eg. N2 0 1 0	36903	
	Physicia	in/	Decedent's Name (First, Middle, Las Marion	M. He	i 1			2. Date of Death		3. Time of Death	
	Medic Examin	cal	4a. Facility Name (if not institution, give				r Location of Death	4c. County of Dea	ath		
	Funeral	and the	Stella Maris 5. Social Security Number 6. So	ex 7. Age	(In yrs. last birthday)	Time	onium I If Under 24 Hrs.	8. Date of Birth	Balti 9.Bi	more rthplace (State or Foreign	
	Director		220-18-9111	□ M 2 □X	87 Yrs.	Months Days	Hours Min.	June 28,	1923 M	aryland	
	show d at	tor	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Loc					10d. Inside City Limits	
	he Man or 28a- e notifie	Direc	MD Balti	more	Towso	10f. Zip Code		10	Og. Citizen of What C	1 Yes 2 No ountry?	
	th with t ns 23a must be	Funeral Director	7510 Far Hills			2128			Og. Citizen of What C		
920	je 1 and 2 should be filed within 72 hours after death with the Maryland t of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 💢 Widowed 4 🗆 Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 1 N If Yes, Give Year or Dates.	No.	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Am Black, Whi Specify:		
15-0	72 hour n "natu fedical	Completed	15. Decedent's E (Specify only highest gra	ide completed)	(Give I	lent's Usual Occup kind of work done	during most of wor	king i	16b. Kind of Business	•	
212	f within ygjene. her tha rt, the N		Elementary/Seconday (0-12)	College (1-4 or 5- 5+	Assiis	tant Dir	ector of		State of	Maryland	
land	be filectental Hirked other	To Be	17. Father's Name (First, Middle, Last) Harry C.	Heuisler	, Jr.		18. Mother's Nar May	ne (First, Middle, Ma E .	aiden Surname) Kline		
Maryland 21215-0036	should h and M 7 is ma traumat		19a. Informant's Name/Relationship (T)	• •				ral Route Number, C	City or Town, State, Z	ip Code)	
ore, I	of Healt of Healt fitem 2 r other		Robert J. Heil-s 20a. Method of Disposition	•	20b. Place of Dispo		1		20c. Location - City o	r Town, State	
Baltimore,	permit. Page Department or Important: If any injury or once.	1	1	y)	Moreland	Mem'l P	ark 11/	/30/10	Baltimore		
Ba	Department of the control of the con	J. J	21. Signature of Funeral Service Licens	[∞] William	G. Dau	1050 Yor	k Rd., To	ick lowson owson, MD	21204	Home, Inc.	
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line.			ig, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death	
	Medical Examiner		disease or condition resulting in death)		GE RENAL D consequence of):	ISEASE					
		ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of):						
B	executed lan and urial-transit	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	cDue to (or as a	consequence of):						
	te be ex nysician ne buria										
Box 68760	eath certificate be e attending physicie d for use as the bur	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o					23d. Date of delivery		
. Box	ires that the death signed by the atterd be detached for i	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 📉 No 9 ☐ Unknown	1		Ectopic pregnand Other (specify)	СУ		Month	Day Year	
P.O.	s that th gned by be detac	by Pr	Part II. Other significant conditions co	ontributing to death bu	t not resulting in the u	nderlying cause gi	ven in Part I.			the cause of death?	
ords,	require been si should I	leted						1 ∐ Yes 24a. Was an		Probably 4 X Unknown utopsy findings available	
of Vital Records,	The law cate has page 2 s	Completed by						autopsy perform 1 🗆 Yes 2.	ed? prior to death? X No 1 □ Ye	completion of cause of s 2 No	
/ital	ysician: The is certificate director, pag		25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	Hospital:	nt 2 🗆 ER/Outpatien	Oth	ace of Death (Chec		on 6 M Other (Spec	city) HOSPICE	
of/	ing Phy I. After this uneral d		27. Manner of Death 1 🛣 Natural 5 🗆 Pending	28a. Date of injury (Month, Day,	28b. Time of	28c. Injur	y at	28d. Describe how		ny) nobi ion	
Division	or Attend fter death irector: / n by the f	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		y - At home, farm, stre (Specify)		Yes 2 ☐ No	28f. Location (Stre City or Town,	et and Number or Ru State)	ıral Route Number,	
	Hospita 24 hours Funeral sted filled	Medical ((Check 2 Medical Exami	sician: To the best of mer: On the basis of example Practioner: To the b	amination and/or invest	igation, in my opinio	on, death occurred a	at the time, date and	place, and due to the	cause(s) and manner stated.	
	To the within 2 To the comple	2	29b. Signature and title of certifier	Whe	te CAN	29c. License			d. Date signed (Mont		
	15		30. Name and address of person who c								
	Stat	.0	JUNECIA WHITE, C		Signatur Salgnatur		TIMONIU	M, MD 210	093		
	Registra	ar	MAN S A SOLO	Cleaner &	. Marie						

State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year HOLZMAN AM EDWARD 201C Medical Wenn ber 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 \ XM 2 \ F Months Days Hours Min. 0972271924 Yrs. **Director** 214-22-3625 86 MD Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 ☐ Yes 2 🛣 No BALTIMORE BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7 SLADE AVENUE. 21208 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. "natural", or ρ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 XNo Specify: Specify. 3 Divorced 4 Divorced Completed WHITE the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ACCOUNTING CERTIFIED PUBLIC ACCOUNTANT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ **AVRAHAM** HOLZMAN **FANNY** GREENSPAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SLADE AVENUE, #401, BALTIMORE, MD LOTTA HOLZMAN/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ∏ Burial 2 ☐ Cremation 3 ☐ Removal from State CHEVRA AHAVAS CHESED 11/23/2010 4 ☐ Donation 5 ☐ Other (Specify) RANDALLSTOWN, MD 21. Signature of Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Scott 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ Myocaed disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iiniury and -trans that initiated events resulting in death) Last Due to (or as a consequence of): physician a Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Chronic Kidney Completed Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 2 🗹 No Other: ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? s after death.

I Director: After to in by the funeral Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined hin 24 hours at the Funeral D mpleted filled is Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month. Dav. Year) RES- 600 Nev 22, 2010 cause of death (Item 23a) (Type, Print) 30. Name and address of person who complet Hospital of MI Sinai ndlinger

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NOVEMBER Physician/ **ELLSWORTH** HINKLE Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Dea BNHE BACHMORE WACHINGTON Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Birthpic. Cou*ntry)* WV **Funeral** Months 1 🕅 📈 2 🗆 F Hours (Month, Day, Year) APRIL 3, 1926 214.24.6464 Director Usual Residence of Decedent or 28a-f show be notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2XX No SEVERN ANNE ARUNDEL 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? "natural", or items 23a o Funeral USA 7714 TWIN OAKS RD. 21144 12. Was Decedent Ever in U.S.
Arrived Forces?
1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married Black, White, etc. Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. 3 Widowed 4 Divorced WHITE Year or Dates. WW |] event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) Health and Mental Hygiene. GENERAL MOTORS WELDER 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ WILLIAM E. HINKLE LUCY MEADOWS other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7714 TWIN OAKS RD. SEVERN, MD 21144 WIFE LORETTA HINKLE NATE Important: If item any injury or othe 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of 1 XX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MEADOWRIDGE MEMORIAL PARK: NOV. 22, 2010 ELKRIDGE, MD 21. Signature of Funeral Service Lic FINA FUNERAL HOME P.A. CHECORY FINE M01148 426 CRAIN HWY SW GLEN BURNIE, MD 21061 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) BNGELTIVE Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence of the attending physician and hed for use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IÉ FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached formpleted filled in by the funeral director, page 2 should be detached for the funeral director, page 2 should be detached for the funeral director, page 2 should be detached for the funeral director, page 2 should be detached for the first page 3. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No To Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. d cause of death (Item 23a) (Type, Print) d address of person who c 31. Date filed (Month, Day, Y

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State

Registrar

9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Vear Physician/ WILLIAM IRIZARRY 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** MEDICAL IMO AND If Under 1 Year If Under 24 Hrs Months Days Hours Min 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** Months Min. (Month, Day, Year April 30, 19 1 X M 2 □ F Puerto Rico Director 69 581-76-6464 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Exeminer must be notified at. Director Anne Arundel 1 Yes 2 X No Fort Meade Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20755 8812 Costin Loop United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black White etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 X Yes 2 □ No Specify: Puerto Rican Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 NYC Maintenance Worker State Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Modesto Irizarry Emmanual Irizarry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond Irizarry/Son 8812 Costin Loop, Fort Meade, Maryland 20755 20b. Place of Disposition (Name of cemetery, crematory or other place)
West Arundel
Crematory 20a. Method of Disposition November 23 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2010 Odenton, Maryland 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 11411 Annapolis Road, Odenton, Maryland 21113 21. Signature of Funeral Service Licensee MO1386 23a. Part 1. Executed disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final (Acute Hyelogenous Leukemis Physician/ Compliantion of AML Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to (or as a consequence of attending physician and for use as the burial-transi resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be a within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physicia completed filed in by the funeral director, page 2 should be detached for use as the burn completed filed in by the funeral director, page 2 should be detached for use as the burn. Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2X No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Registrar DHMH 17 Rev 7/2009

State

RAMYA SWAMY,

RAMYA SWAMY, MD Resident

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAMYA SU

11/22/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Vernell B. Johnson 6:56 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Union Memorial Hospital Baltimore If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Gountry S.C. July 8, 1923 Months Hours 213 32 6000 87 Director Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Baltimore ty Yes 2 ☐ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 1314 N. 21213 Chester St. USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No the Medical Examiner Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: Black 3 √ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Catholic Charities 12th Seamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F .. Page 1 and 2 should be fill tment of Health and Mental tant: If item 27 is marked of ၉ Moses Langley : If item 27 is marke or other traumatic Harriett R. Morrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Levolia B. Johnson (daughter) 8349 Township Drive, Owings Mills, MD Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 → Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place) Department of Important: If any injury or Årbutus Mem.Pk. Nov. 27, 2010 Balto, Md. Sign vir of Funeral Service Licensee 22. Name and Address of Facility
Calvin B. Scruggs Funeral Home
1412 E. Preston St. Balto, Md. Part 1. Enter the disease, or complications that caused the ceath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician Gastrointestinal Bleeding 1 day disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician d be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypotensian 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No End Stage Renal DIJEAN on Hemodralysis 24a. Was an After this certificate has autopsy Man ST Elevation Mys cardin 25. Was case referred to medical examiner?

1 Yes 2 No completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Investigation Accident 24 hours after deat Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) AT 2438946-A7 M.D 11/22/10 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Ranne

31. Date filed (Month, Day, Year)

Foster

Baltimore,

MD

21218

E. University

2. Registrar's Signature

201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^{Day}4 2010 EDWARD JOSEPH KRAWCZYNSKI November 8:10 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner STELLA MARIS HOSPICE Baltimore County Timonium Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Months Days Hours (Month, Day, Y 216-30-9986 79 Director Maryland Usual Residence of Decedent 10b. County 10d. Inside City Limits at 10a, State 10c. City. Town or Location Director notified 28a-f 1 ☐ Yes 2 🌠 No Maryland Baltimore County Nottingham 10e. Street and Number 10f. Zio Code ò 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral with 1 9402 Belair Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 1 Ves 2 1 No 50-53 Black White etc. 1 X Never Married 2 Married 1 Yes If Yes, Give þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) United States Elementary/Seconday (0-12) College (1-4 or 5+) Letter Carrier 12 Postal Service 27 is marked other r traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John P. Krawczynski Sadowski Katherine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Katherine Geiman (Niece) E. Northern Parkway, Baltimore, Maryland 21206 Important: If item 2 any injury or other tonce. 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date ₹ ⊠ Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) St. Stanislaus Cem. 11/27/2010 Baltimore, Maryland 21. Signature of Fund al Sautina Liverage MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 Martin D. Lawson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ END STAGE PARKINSON'S DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last and -trar Due to (or as a consequence of): attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Vital Records, P.O. Box 68760 the as LE FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month Day Year signed by the at d be detached for 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I **|** 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 autopsy performe this certificate 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \square Nursing Home 5 \square Residence 6 X Other (Specify) **HOSPICE** è 2 X No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Division of funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 24 hours after death.

Funeral Director: After 1 X Natural 5 Pending work?
1 Yes 2 No Accident the Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2. 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 2010 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

8:10

NOVEMBER

EDWARD KRAWCZYNSKI

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day 6, 2616 300pm **Physician** nol /Medical 4c. County of Deatl 4b. City Town, or Location of Death Facility Name (If not institution. give street and number) Examiner Randallstown HOSP. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🔀 F Yrs. Maryland Director 214-24-5752 83 Feb 26, Usual Residence of Decedent filed within 72 hours efter death with the Maryland 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location 23a or 28a-f ehow the Madical Examiner must be notified at 1 ☐ Yes 2 No MDBaltimore Owings Mills Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21117 9773 Groffs Mill Drive Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "naturel", or Iteme 11. Marital Status Black, White, etc. 1 Yes 2X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Specify δ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiane. College (1-4or 5+) Elementary/Secondary (0-12) Sears 12 Sales Representative or other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) permit. Peges 1 and 2 should be fitted Department of Health and Mental Hy Important: if Item 27 is marked other permit of the fraumatic event app. 17. Father's Name (First, Middle, Last) Be Germano Maria Mento Giovanni ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4744 Buxton Circle Cheryl D. Schreiber Daughter Owings Mills, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Surial 2 ☐ Cremation 3 ☐ Removal from State 11/30/10 Baltimore, MD Holy Redeemer Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road ELINE FUNERAL HOME keisterstwon, MD 21136 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence Examiner Ischem: St. uential / list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner attending physician and I for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 Tes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No s been si Completed 24a. Was an autopsy performed2 1 ☐ Yes 200 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes ☐ No No. certificete or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) After th 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 No M investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Contifying Physician: To the bast of my knowledge death occurred at the time date and place, and oue to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and margner stated. 29a. Certifier Medica (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29h. Signature and Me of certifie November 26,2010 30. Name and address of derson who completed cause of death (Item 23a) (Type, Print) chwartz, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Agha Tahir Khan November 9:19AM 7.61 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sa Honore Sina; Hospita If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) India 1 1 M 2 1 F Days Hours (Month, Day, Year) Ct. 23. 1940 70 Director 069-74-3725 Oct. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery SIlver Spring 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral USA 20904 1005 Hobbs Drive . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 X No 1 Never Married 2 X Married ☐ Yes 1 ☐ Yes 2 X No Specify: Specify: Indian If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Accounting Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Amtul Hafeez Begum Agha M. Abdul Rahim 8gheut Known 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8510 Huntingspring Dr., Lutherville, MD 21093 Dr. Agha S. Khan (Brother) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Mem. Park 11/29/10 Sykesville, MD Signature of Funeral Service License 22. Name and Address of Facility ^{acility} HAIGHT FUNERAL HOME & CHAPEL,PA Sykesville, MD 21784 Page Haught 2 PO Box 195 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Gam Negative disease or condition resulting in death) day Medical Due to (or as a c) sequence of): Examiner 2 week Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Type I Diabete, Mellitus 2 No 3 Probably 4 Unknown 1 🗌 Yes Kulney Osease 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending 2 Accident
3 Suicide Investigation
6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signat 29d. Date signed (Month, Day, Year) 04186 November 26, 2010 B address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

Greene Tree Road Suite 420 Baltmore MD 21208

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1, per MD g909 11/29/10 TT
State of Maryland / Department of Health and Mental Hygiene, Amend #1, per 1 - For State Registrar Certificate of Death Reg. No. Svetlana Reinish Khodarkovsky 1. Decedent's Name (First, Middle Last) 2. Date of Death 3. Time of Death Month Year **Physician** 2010 Vovember odeu /Medical 4c. County of De cility Name (If not institution treet and number ocation of Death Examiner Birthplace (State or Foreign Country) Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Funeral Months Hours Days 1 □ M 2 □ F Director 03/28/1938 RUSSIA 214-90-4070 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD BALTIMORE RANDALLSTOWN 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code , or items 23a or 9005 HAMOR ROAD 21133 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2√ No If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 □ No Specify: þ Specify: WHITE 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry JOHNS HOPKINS than College (1-4or 5+) Elementary/Secondary (0-12) RESEARCH ASSISTANT UNIVERSITY h and Mental Hygie 7 is marked other tl 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SAMUEL REINISH LIDIA DIKERMAN ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is MARK KHODARKOVSKY/HUSBAND 9005 HAMOR ROAD, RANDALLSTOWN, MD injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 MBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ARLINGTON CHIZUK AMUNO 11/24/2010 BALTIMORE, MD of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. any 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or co shock, or heart failure. List only or complication. Y at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Immediate Cause (Final 5 **Physician** disease or condition resulting in death) /Medical Due to (or as a 1 nsequence of); Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a consequence of) Examiner requires that the death certificate be executed and burial-trai Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: IF FEMALE: 23b. Was decedent pregnant 12 mounts? 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☑No P.O. 9 Unknown signed by 1 I be detacf 23e. Did tobacco use contribute to the cause of death? not resulting in the underlying cause given in Part I. Division of Vital Records, 2 🗌 No 3 Probably Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death? has page 2 certificate 2 □No 1 Yes 2 □ No 25. Was case referred to nedical examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Pesidence} \) 6 \(\text{Other} \) (Specify) 1 ☐ Yes 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Hospital or Attending 1 Matural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 124 hours after death.

le Funeral Director: / 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier completely (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of M.D address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 4a, per MD \$\frac{4909}{51} \frac{11}{29} \frac{10}{10} \text{TD} epartment of Health and Mental Hygiene For State Registrate Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER 2010 6:15 AM R KALB SYLVIA Medical Eacility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOWARD LORIAN NURSING HOME COLUMBIA Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Min. 1 🗆 M 2 🖵 F Months Hours 04/91/271/930 Director 214-26-6355 80 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 Yes 2 No BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3410 ASSOCIATED WAY, #317 21117 USA 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No by 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes. Give Specify: "natural", Completed 3 → Widowed 4 □ Divorced WHITE Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ACCOUNTING MUSIC other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ SPITALSKY JANOFSKI IRVING ANNA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .2 Page 1 and 2 siment of Health amt: If item 27 i 23 BOURBON COURT, PARKVILLE, MD ALBERTA EATON/FRIEND 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State Important: If it any injury or o 1 Demoval from State 11/24/2010 BALTIMORE, MD 4 Donation 5 Other (Specify) SHAAREI TFILOH CEM. 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final STAGE Physician/ RENAL disease or condition resulting in death) nonety Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 9 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? GI BLEED 24a. Was an page 2 autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) To the Funeral Director: After this completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation after death 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00053150 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 40 21045 State Registrar

10-08909 Jerry Kowalow Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

State of Maryland / Department of Health and Mental H

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		1- For State Registrar			Certific	ate of	Death			- R	eg. No	U	1 0	00010
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Medical Exam	iner	JERRY	KOWA		Jerzy		alow_			Novembe	r 20,	2010		1532 hrs
		4a. Facility Name (if not institution Greater Baltimore Me		umber)		4	o. City, Town, o Towson	r Location	of Death			c. County of Baltimore		ntv
Funeral		5. Social Security Number	6. Sex	7. Age (I	n yrs. last birt	hday)	If Under 1 Ye	ar I If Unde	er 24Hrs.	8. Date of Bi				nplace (State or Foreign
Director		213-94-7611	1XM 2 F	, ·	46	Yrs.	Months Da			02/1	•			intry)
		Usual Residence of Decedent	I A IVI Z F		40	115.				02/1	9/1	904		POLAND
any		10a. State 10b. County		100	c. City, Town	or Locatio	n							10d. Inside City Limits
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	}	30. Name and address of person	who completed caus	se of death	(Item 23a)						_			
		Pamela E. Southall, M				111	Penn Stree	t, Baltim	ore, MD	21201				
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. Box 68760	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transitied filled in by the funeral director, page 2.	Physician/Medical	IF FEMALE: 23b. Was decedent pregna in the past 12 months 1 Yes 2 No 9 Unknown	iii.	1 Live I	come of pregnar Birth 2 Fetal nant at time of do	death 3	Ectopic pregna Other (specify)	ncy				23d. Date of Month		,	ear .
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Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year **Physician** Knight Elwood 2230 20 2010 Kovember /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner N/A <u>Johns Hopkins B</u>ayview Medical Ctr. Baltimore City If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months Yrs. Director May 21,1956 Maryland 216-68-6394 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State show Department of Health and Mental Hygiene. Important; or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If we l'edical Examinat must be multised at once. 1 ☐ Yes 2 XNo Director Dunda1k MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21222 8344 Bletzer Road United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black White etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 1 □ Never Married 2K Married 2 No altimore, Maryland 21215-0036 1 ☐Yes 2 No Specify Specify: White <u></u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years College (1-4or 5+) <u>Meat Cutter</u> Gaint Foods 2 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Catherine Nuth ျှ Edward L. Knight 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Lorraine K. Knight (Wife) 8344 Bletzer Road Dundalk, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 3 Removal from Stat 1 Burial 2 ☐ Cremation 5 ☐ Other (Specify) Meadowridge Mem. Park 11/24/2010 Elkridge, Maryland 4 ☐ Donation 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave, Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician YEAY S 95CV disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Jusease or injury that initiated events Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trar resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician use as attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 ☐ Yes 2 ☐ No 3 Probably 4 ₹ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∰Yes 2 No 1 ☐ Inpatient 2 MER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After s after dea. (al Director: Aftr hy the fir 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours a To the Funeral D Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hopking Bry view Medical Center s. Bessman 31. Date filed (Month, Day, Year) State

Registrar
DHMH 17 Rev 1/2001

29

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G910 12/14/10 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JEAN LEIZEAR Month NOVEMBER Year PM 6:20 Medical 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOPTHWEST TO A HOSPITAL RANDALLSTO WN Baltimore 5. **Sorial** Security Number 212-20-5045 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗓 F (Month, Day, Year) Country)
Maryland Hours 87 Director Yrs FEB 1923 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Maryland Carroll 1 🗆 Yes 2 🖁 No Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 7200 Third Ave. Apt. C111 21784 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Armed Forces? 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Widowed 4 ☐ Divorced 1 ☐ Yes 2 😾 No Specify: Completed Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Dom<u>estic</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Thomas Smith permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Opal Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles R. Leizear, II/son 200 Southampton Circle Hoschton, GA 30548 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 12/01/2010 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation Service Sykesville, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Haight Funeral H P.O. Box 195 lome & Chapel, 2P A kesville, MD, 21784_(4<u>10-795-1400)</u> INC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate terval Between Interval Between Onset and Death Immediate Cause (Final .Physician/ OSTRI DIFFICILE disease or condition D COLITIS Medical resulting in death) Due to (or as a consequence of): Examiner Secuentially list continues if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day been signed by the a should be detached t Year 9 Unknown ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? ATRIAL FIBRILLATION WITH RAPID VENTRICULAR Completed 1 Yes 2 No 3 Probably 4 Unknown RESPONSE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate 2 No 1 Yes or Attending Physician: 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 2 **X**No 1 🗌 Yes မ Other: 1 Plnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 1 Natural
2 Accident
3 Suicide
4 Homicide 28c. Injury at 28d. Describe how injury occurred 5 \square Pending work? Investigation 2 🗌 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D54352 NOVEMBER 27 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8 MIRCEA TODOR NORTHWEST HOSPITAL SHOLD COURT ROAD RANDALLSTOWN MD 21133 31. Date filed ₩onth, Day, Year) 32. Registrar's Signature State 2010 Registrar

		For State Registrar	State of Maryla		tificate of D			leg. No.	
Physici	an/	1. Decedent's Name (First, Middle, Last)	1		-		2. Date of Deat Month	er ^{Day} o, 2010	3. Time of Death
Med	ical	Debra Jean Lo 4a. Facility Name (if not institution, give stre	oher		4h City Town or	Location of Death	Novembe	4c. County of Death	07:47 A M
Exami	ner	502 West Court	, or and names,			Burnie		Anne Aru	ndel Co.
Funera Directo		5 Social Security Number 6 Sex	7. Age (In yr:	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 11,	Year) 1952 Mary	place (State or Foreign try) 1and
ind show at	'n	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Loc	eation	-		1	0d. Inside City Limits
Maryla 28a-f s	Director	Maryland Anne Arur	ndel Co.	Glen Bu	rnie				1 ☐ Yes 2X No
s 23a or	Funeral D	10e. Street and Number 502 West Court			10f. Zip Code 21	1061		10g. Citizen of What Cour United Sta	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hipty or other traumatic event, the Medical Examiner must be notified at once.	ed by Fur	11. Marital Status 12 1 Never Married 2 Married 3 Widowed 4 🌠 Divorced	. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.		Vas Decedent of His Yes, specify Cubar		cify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Wh	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", o any hijury or other traumatic event, the Mediral Exam once.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Seconday (0-12)		(Give I	lent's Usual Occupa kind of work done d O NOT use retired)		ng	16b. Kind of Business Inc	-
Id 2.	Be	12 yrs. 17. Father's Name (First, Middle, Last)] Se	cretary	18. Mother's Name	e (First, Middle, N		Verment
ylar ild be f Menta narked artic ev	₽	Walter McKenzie,				Imogen	e Coat	tes 	
Mar 12 shou alth and 27 is m		19a. Informant's Name/Relationship (Type, Ms. Shannon Loher			ig Address (Street a lest Court			City or Town, State, Zip C Maryland 2	Code) 21061
Ore, le 1 and t of Hee If item or othe		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Re		o. Place of Dispo cemetery, cren	sition (Name of natory or other place	е)	Date	20c. Location - City or To	own, State
Itim iit. Pag artment ortant:		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee			Crematory			Glen Burnie Funeral & Cr	
Dep de de de de de de de de de de de de de		11002		1121 Se	rvices P	A; 1 2nd	Ave SW;	Glen Burnie	
Enysician Medica Examine		23a. Part 1. Enter the disease, or comples shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	cause on each line.	equence of):	Avtic Mell				Approximate Interval Between Osset and Death
ificate be executed g physician and as the burial-transit	Medical Exa	that initiated events resulting in death) Last	Due to (or as a cons	equence of):	-				
Box 68 death certific he attending led for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	s. If yes, outcome of preg 1 ☐ Live Birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of delive	ery Day Year
1S, P.O. uires that the in signed by tuild be detach	P	Part II. Other significant conditions contr	ibuting to death but not	resulting in the u	nderlying cause giv	en in Part I.		bacco use contribute to the	
5 0 O	Completed						24a. Was a autops perfor 1 Yes	sy prior to co	psy findings available mpletion of cause of 2 ANo
Vital Rec nysician: The la is certificate ha director, page?	Ba	25. Was case referred to medical examiner? 1 Yes 2 No	spital:		Othe	ace of Death (Checker:			
- 2 2 0	cate: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	1 ☐ Inpatient 2 28a. Date of injury (Month, Day, Year)	28b. Time of	28c. Injury work	at		ence 6 Other (Specify ow injury occurred	
Division of To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe		eet, factory, office		28f. Location (St City or Town	reet and Number or Rural n, State)	Route Number,
e Hospit 124 hour e Funera leted fill	Medical	(Check 2 Medical Examiner	: On the basis of examina	tion and/or invest	tigation, in my opinio	n, death occurred at	the time, date an	se(s) and manner as state and place, and due to the ca cause(s) and manner as st	use(s) and manner stated
To the within To the comp	2	29b. Signature and title of certifier	1) 45		29c, License	number 791	2	29d. Date signed (Month,	Day, Year)
3		30. Name and address of person who com	pleted cause of death (It	em 23a) (Type, F	Print) Le les	Cinture	un M	1021090	
St Regist	ate	31. Date filed (Month, Day, Year) NOV 2. 9. 2010	32. Registrar's Sig	pature fact	W.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** WILLIAM I. LEE :51 NOV 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A HOSPITA LTIMORE AGNES Birthplace (State or Foreign
Country) If Under 1 Year | If Under 24 Hrs Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Hours 1**X** M 2□ F Months Days 066-22-4488 Director 81 3/1/1929 NEW YORK Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show the Medical Examinishment be notified at COLUMBIA 1 ∏Yes 2 X No Director HOWARD MD 10a. Citizen of What Country? 10e. Street and Number 10f. Zip Code items 23a or 21044 USA Funeral 5317 HIGH WHEELS COURT 12. Was Decedent Ever in U.S. Armed Forces? 1∑ Yes 2 □ No If Yes, Give Year or Dates: KOREAN Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 □Yes 2 □No Specify: þ 3 Widowed 4 Divorced 'natural", WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) LIFE INSURANCE SALES 12TH GRADE 7 is marked other traumatic event, II 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Health and Mental em 27 is marked o JOHN J. LEE UNA HOLM ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13 DANFORTH COURT TOWSON, MD VALERIE BAER/DAUGHTER Department of Health Important: If item 27 any injury or other trong once. 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition DULANEY VALLEY MEM. 1 XBurial 2 Cremation 3 Removal from State GARDENS 11/27/2010 COCKEYSVILLE, MD
22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A.
8521 LOCH RAVEN BLVD. TOWSON, MD 21286 11/27/2010 COCKEYSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) MO1139 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician YEARS HTHER DICLEROTE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 1 Yes 2 No certificate Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 / Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural To the Hospital or Attendi within 24 hours after death To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State
Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) NOV 2 9 2810

KONQUII

JONATHAN

gw/Va

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Rose Μ. Laage Medical November 10:25 P M 2010 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Futurecare-Chesapeake Arnold Anne Arundel Social Security Number If Under 1 Year I If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min. 213 10 6579 Director 1907 103 Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits Maryland 1 Yes 2 No Anne Arundel Arnold 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 305 College Parkway 21012 United States items 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian o ģ 1 Never Married 2 Married within 72 hours after Black, White, etc. Baltimore, Maryland 21215-0036 🗌 Yes 2 💢 No If Yes, Give Year or Dates permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exa 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Self Employed Candy Maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Debow / Nephew 1014 Roseann Rd. Glen Burnie, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ho1v Cross Cemetery 11/24/2010 Brooklyn Park, Maryland 21. Signature of Fundamental Service Licenses 22. Name and Address of Facility
Kirkley-Ruddick Funeral Home, P.A.
421 Crain Hwy. SE; Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final t and Death Physician/ disease or condition Medical resulting in death) Due to (or s a consequence of): Examiner Sequentially list conditions, if any leading to his redicte cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): signed by the attending physician and d be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available has autopsy prior to completion of death? cause of certificate performed 1 🗌 Yes 2 🔽 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗆 Yes 2 1 No 욘 Other within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? Accident Investigation 1 Tyes 2 🗆 No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. of certifie 29d. Date signer (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) Elliota Gorbal MudiJa m1)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month NO 2010 Physician/ Elizabeth McCroden McConaha Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **E**xaminer Union Memorial Hospital N/ABaltimore 8. Date of Birth (Month, Day, Y March 13 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Country) Maryland Months Days Hours 218-22-8178 97 **Director** Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location notified at Director 1X Yes 2 ☐ No N/A Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number ō the Medical Examiner must be Funeral 23a 2639 North Calvert Street 21218 U.S.A items ; within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🕅 No ò þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: If Yes, Give Year or Dates Specify: White "natural", 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) vears Dance Instructor Dance Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ٩ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatto 6 McCroden Smith Alice Lawrence other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joy Martin Harvest Road Baltimore, Maryland (Friend) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 \square Cremation 3 \square Removal from State Most Holy Redeemer Cemetery 12-1-10 4 Donation 5 Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee tchell-Wiedefeld Funeral Home Inc. 500 York Road Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21212 Approximate Interval Between Onset and Death Immediate Cause (Final cuith gram positive coci, negative ruds Physician/ disease or condition Medical resulting in death) Examiner 48 hrs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examir sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 d guipt se as t IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month for Day Month 5 Other (specify) Pregnant at time of death signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2 □ No 24a. Was an s certificate has b lirector, page 2 sl autopsy To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) hours after death. Ineral Director: After this certific of filled in by the funeral director, Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes ည Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred Certificate: 5 Pending Natural 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral I

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature applittle of ce 29d. Date signed (Month, Day, Year) MD AT243 8946 C3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nion 31. Date filed (Month; Day, Year) 32. Registrar's Signature State 9 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 20, 2010 5:00pm\ Miller Valgerd Marie 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Owings Mills Baltimore 9902 Middle Mill Drive . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth 1 🗆 M 2 🔀 F Months Davs Hours Min. (Month, Day, Year) ec 12, 1944 Maryland 65 Dec 212-48-7308 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c. City. Town or Location 1 Yes 2X No Owings Mills Baltimore 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? U.S.A. 9902 Middle Mill Drive 21117 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? 1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes Give 3 ▼ Widowed 4 □ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Education Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First. Middle, Last) Stefansson John Daniel Valgerd Bain 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD21074 Diane Roloson Daughter 650 Marpete Drive Hampstead, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 XCremation 3 Removal from State 11/23/10 Hampstead, Maryland Carroll Cremation 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road 21136 J. Wayne Osterling ELINE FUNERAL HOME Reisterstown, 26a Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death

Physician/ Medical Examiner

> burial-transit and

attending physician for use as the buria

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after death. Director: After

24 hours a Hospital

To the I within 2 To the I

funeral director,

Division of Vital Records, P.O. Box 68760

or Attending Physician:

Physician/

Medical

10a. State

MD

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Director

notified 28a-f

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death with the Maryland

Examine Physician/Medical IF FEMALE: þ Completed Be

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Certificate:

Medical

resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last

23b. Was decedent pregnant

Immediate Cause (Final

disease or condition

h -	HTW
D	Due to (or as a consequence of)
c. –	Due to (or as a consequence of)
d	
1	

00- 16
23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal de
4 Pregnant at time of deat
Q I Hokoowo

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Due to (or as a consequence of):

s, outcome of pregnancy	
Live Birth 2 Fetal death	3 Ectopic pregnan
Pregnant at time of death	5 Other (specify)
Unknown	

	23d. Date of delivery
topic pregnancy ner (specify)	Month Day

in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
Part II. Other significant condition	s contributing to death but not resulting in the underlying cause given in Part I.

	1 □ Yes 2 €	No 3 □ Probat	oly 4 🗌 Unknow
	24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No	24b. Were autopsy prior to comp death? 1 \(\sum \text{ Yes} 2	/ findings available letion of cause of ☐ No
26. Place of Death (Check on	ly one)		

23e Did tobacco use contribute to the cause of death?

25. Was case referred examiner?	to medical
27. Manner of Death	
1 Natural	5 Pending
2 □'Accident	Investigation
3 Suicide	6 Could not be

Suicide

4 Homicide

only one)

1 🗆 Inpatient 2 🗆	ER/Outpatient	3 🗆 1	DOA	Other: 4 [
28a. Date of injury (Month, Day, Year)	28b. Time of injury	М		Injury at work? 1 ☐ Yes
28e. Place of Injury - At he building, etc. (Specify		t, facto	ry, of	fice

DOA 4 ☐ Nursing Ho	ome 5 Residence 6 Li Other (Specify)
28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
ory, office	28f. Location (Street and Number or Rural Route Number City or Town, State)

29a. Certi		Certifying F
(Che	ck 2 L	Medical Exa

1 E	Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 [Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3"	Sertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

9D, Signaga evand title of cert	moi)	
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address of person who comple

determined

Hospital:

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29c. License number

29d. Da	ate signed (Month, Day, Year)
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31	Date filed	(Month	Day	Year

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend #8 per Fh g910 12/3/10 TT
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 3.25 P.M Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 648 HOLLY CIRCLE HARFORD CO ABERDEEN 5. Social Security Number 6. Sex 1 🛣 M 2 🗆 F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth June 20 **Funeral** g. Birthplace (State or Foreign Months Min Hours Director MARYLAND 56 Yrs. 1954 214-64-2937 Usual Residence of Decedent or 28a-f show 10a. State 10b. County filed within 72 hours after death with the Maryland must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MARYLAND HARFORD CO 1 Yes 2 X No ABERDEEN 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Iral", or items 23a Examiner must be Funeral 648 HOLLY CIRCLE 21001 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Completed by "natural", If Yes, Give 1 Yes 2 XXNo Specify: 3 Widowed 4 Divorced Specify: WHITE Year or Dates other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. 12th grade N/A DISABLED Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 OLIVER H McINTYRE ELLEN J. SULLIVAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>.s</u> permit. Page 1 and 2 st Department of Health a Important: If item 27 is Carol Ann McIntyre/Wife 2606 Burridge Rd., Baltimore, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State injury or 4 Donation 5 Other (Specify) METRO CREMATORY 11-23-10 BALTIMORE, MARYLAND 21. Signature of Funeral Service Lie WILLIAM C BROWN COMM FUNERAL HOME-HARFORD, 321 S PHILADELPHIA BLVD, ABERDEEN, MD 21001 any Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause an each line. mode of dying, such a cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or and the burial-trar that initiated events resulting in death) Last Due to (or a equerice of): been signed by the attending physician should be detached for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 use as 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Unknown Month Day Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Nnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy performed? Yes 2 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ပ 2021 Other: ER/Outpatient 3 □ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation completed filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge,
Medical Examiner: On the basis of examination and/o 29a. Certifier death occured at the time, date and place, and due to the cause(s) and manner as stated. If hyestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of urred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certi 30. Name and address of person who completed chuse of death (Ita 31, Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- State Registrar Amend Items 28 1 1 - Per Maryland Consumption of Health and Mental Hygiene Certificate of Death Reg. No. 0 0 3	6923			
	Physici	an/	1. Decedent's Name (First, Middle, Last) 2. Date of Death 3.1	Time of Death			
	Medi	cal	Anthony Matchell 11-17-2010 1	0'.05 pM			
	Exami	ner	45. County of Death	,			
1	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign			
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	and show	5	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Ins	side City Limits			
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	th the	a D	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?				
	ath wii	Funeral Director	40/8 Starbrook Road 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No.) 14. Reco. American Ind.				
9	within 72 hours after death with the Maryland liene. sr than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by Fi	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban Mexican, Puerto Rican, etc.) 14. Race - American Ind Black, White, etc.	ian,			
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Maryland	ge 1 and 2 should be nt of Health and Men if item 27 is marke or other traumatic		19a. I ant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or ural Route Number, City or Town, State, Zip Code)				
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altimore,	Pa and Pa		1 V Burial 2 Cremation 3 Removal from State Commetery, crematory or other place) 4 Donation 5 Other (Specify) Commetery, crematory or other place) 11-33-2010 - Gure / Mi				
Balt	permit. Pag Department Important: any injury conce.		21. Signature of Funeral Service Lizensee 22. Name and Address of Facility Quenn C. Green Etonera				
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	Examiner						
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8	death certificate be executed the attending physician and ed for use as the burial-transit	dical	d				
876	ng phy as th	Med	IF FEMALE:				
Box 687	eath certifica attending pl	ian/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery				
ă	ilres that the dea	Completed by Physician/Me	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) Month Day 9 Unknown	Year			
P.O.	ned by	oy P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause	e of death?			
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COL	has be	nple	24a. Was an autopsy find autopsy prior to completio	lings available n of cause of			
Be !	sician: The la certificate ha irector, page 2		performed? death? 1 Yes 2 M No 1 Yes 2 N 25. Was case referred to medical	performed? death? 1 Yes 2 No 1 Yes 2 No			
Vita	s certi	To Be	examiner? 1 Yes 2 No Hospital: Other:	trent			
to d	ig ring ter this neral o		27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred	50100			
lo	tendil Jeath. Ior: Af the fu	Certificate:	2 Accident Investigation M 1 Yes 2 No				
Division of Vital Records,	after after Direction by	G	4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route in City or Town, State)	Number,			
	The troping a varieting trysician: The law requires that the within 24 hours after death. To the Funeral Director, After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	MD 2120			
440	ure ru hin 24 the Fu nplete		only one) Nedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) are certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	nd manner stated.			
F	S 2 × ii	2	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yea	ar)			
		-	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) And Lewis Volence VA				
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) And Lewis Villame VA VAOIN Charles Street. Ste 1105. Bathwar. MD	SIZON			
	Stat	e ³	31. Date filed (Month, Day, Year) 32. Registrar's Signature	~ ~ ~ ~ ~			
	Registra	r .	NOV 2 9 2010 Sum S. Janes				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Deborah B. Morrison Medical November 2010 11:00p 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Fairhaven Sykesville If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 💢 F 219-22-5298 (Month, Day, Year h 23 10 MD Director 83 Usual Residence of Decedent 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location Sykesville Director 10d. Inside City Limits notified MD Carrol1 28a-f 1 Yes 2 No ms 23a or must be n 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 7200 Third Avenue 21784 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force þ Black, White, etc. ò 1 XNever Married 2 Married 1 ☐ Yes 2 🗓 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural" Completed 3 Widowed 4 Divorced Specify: white Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 7: ment of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore Sun reporter traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Douglas Raustin Morrison Pauline Frances Pollitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6361 Lakeview Dr., Falls Church, VA 22041 Deborah Hamlin (cousin) 20a. Method of Disposition 20b. Place of Disposition (Name of Department of h Important: If ite any injury or ot once. 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Druid Ridge Cemetery 11-30-10 Pikesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Haight Funeral Home & Chapel Parox Jaight o P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Physician Onset and Death Hn emia Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examir burial-transi Due to (or as a consequence of) resulting in death) Last ng physician as the burial Physician/Medical Box 68760 IF FEMALE: or use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year ed by the 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by the period of the signal of the si 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Hospital or Attending Physician: The law requires Obstudine 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy performed within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, p æ 25. Was case referred to medical 26. Place of Death (Check only one examiner? Hospital: 2 No Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Sursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident М 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certifier D34849 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 645 iberty 1anmo 32. Registrar's Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ McAvoy F. James 24, 2010 November 5:40 a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Brighton Gardens Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Feb. 10 , 1922 Mary land 1 x M 2 □ F Months 214-18-1088 88 Yrs Director Usual Residence of Deceden 28a-f shov 10b. County filed within 72 hours after death with the Maryland Examiner must be notified at 10a, State 10c. City, Town or Location Director MD Baltimore Baltimore 1 Yes 2 XNo 9 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a 6451 North Charles Street 21212 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, à 1 Never Married 2 X Married IX Yes 2 No
If Yes, Give 42-45
Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify. White Completed 3 Widowed 4 Divorced Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. sant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Fireman Engineer Brewery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည С. Catherine Garrish Harry McAvov 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau once, David S. McAvoy-son 3437 Jay Drive, Ellicott City, MD 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Parkwood Cemetery 1 💢 Buria! 2 🗆 Cremation 3 🗆 Removal from State 11/29/10 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Servi ... censee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, MD 21204 William G. Dau 1050 York Rd., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ neumonia LOUR Medical Die to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Month Year detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe Yes 2 No 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ASSUTED Wing 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b Time of 28c. Injury at 28d. Describe how injury occurred FRYIA within 24 hours after death.

To the Funeral Director: After a completed filled in by the funera 1 Natural 5 Pending 1 Tes Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral L Medical 1 Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

670

and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 24, 2010 <u>Francis W. McDonough</u> Medical November 8:10 AM 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Cente Towson Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 D F Months Hours April 10, **Director** 219-30-5103 76 Baitimore, MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits notified 28a-f Maryland Baltimore Lutherville 1 Yes 2 X No 10e, Street and Number ŏ 10f. Zip Code "natural", or items 23a or edical Examiner must be 10g. Citizen of What Country? Funeral 108 Dublin Drive 21093 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ģ 1 Never Married 2 X Married Black, White, etc. If Yes, Give Year or Dates. 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced WII Specify: White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Engineer Electrical Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Anna Marsalek Alfred Thomas McDonough 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7610 Old Harford Road, Baltimore MD 21093 James McDonough/ son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🗆 Burial 2 🕱 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corporation 11/26/2010 Towson, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Towson, MD 21204 Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition Medical resulting in death) Examiner oranary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of Examin Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-tra Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months?

1 Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Day Year ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s autopsy perform 2 🗌 No Yes 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 1 Yes ဂ္ Other: npatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at After 28d. Describe how injury occurred 1 Natural 5 \square Pending work? Accident 2 No after death Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check To the I only one Certifying Nurse Practioner: Te the best of my knowledge. the three date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month) Day, Year) 30. Name and address of person who State Date filed (Month, Day, Year) Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Amend Item Registrar	5 State of M per inf	arylan fn ,g	910-12 Cer	tificate of L	lealti Inb Death	n and M 1	lental Hy	/gien Reg. N	e 2010	3692	7
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	and show at	ō	Usual Residence of Decedent 10a. State 10b. County		10c. City	/, Town or Loc	ation						10d. Inside City Limi	nits
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ryla	should be fill and Mental 7 is marked or raumatic eve	-	Henry William 19a. Informant's Name/Relationship (Ti	Meyer Print		1	1		th J.					
Ma	12 shoalth an 27 is r trau		Mr. Jeff Anderson			1	g Address (Street a Sharp Rd.				-	_ '	o Code)	
ore,	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition 1 Burial 2 Cremation 3			lace of Dispos	sition (Name of eatory or other place			ate		Location - City or	Town, State	
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Σ	spital or ours afte eral Dire		4 E Homiciae actermined	building, etc	. (Specify)					City or To	vn, State	∍)		
	To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one) 2 Medical Exami	ner: On the basis of ex	amination	and/or investi	gation, in my opinior	n, death	occurred at t	he time, date	and place	e, and due to the	cause(s) and manner sta	tated.
	To 1 To t		29b. Signature and title of certifier	7			29c. License				29d, Da	ate signed (Montl	23 2010)
	6		30. Name and address of person who c	ompleted cause of de	ath (Item	23a) (Type, Pr 701 /V	int) Char	4	50	Tow so	IN	MO		
E	Stat Registra		31. Date filed (Month, Day, Year) NOV 2 9 2010	32. Registra	r's Signatu	ire Kal								

	State of Maryland / Department of Health and Mental Hygiene											0				
		Registrar Certificate of Death											3692	8		
ı		hysician/							Sr.		Month	2. Date of Death 3. Time of Death Month Day Year				
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Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		'	Cremation 3	Removal from S	tate	cemetery, cren k Lawn	natory or o	ther place)	11/	24/2010	1		-	Maryland	1
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	the H hin 24 the F mplete		only one) 3 L	Certifying Nur	se Practioner: To	the best of m	y knowledge, d	eath occun	red at the ti	me, date and p	place, and due to the	and place ne cause(s	, and due to s) and manne	the caus	e(s) and manner sta	ated.
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1	Stat	е	31. Date filed (Month, I		32/Reg	istrar's Signat		, ,,	4 CE	i) WVI	-(, ,				
	Registra		NO	V 2 9 20	711 /		a La	1								- 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 11 2010 Marciszewski Μ. Melvin 10:20 a^M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford Brightview Nursing Home Bel Air If Under 1 Year If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Days 1 🙀 M 2 🗆 F Months Hours Min. Yrs 09728/1923 Director 216-14-3892 MD Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10h Counts the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 Ring Factory Road 21014 U.S.A. items 12. Was Decedent Ever in U.S. Armed Forces?

1 🖾 Yes 2 🗌 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. or þ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 27 is marked other than "natural", traumatic event, the Medical Exar Completed 3 X Widowed 4 Divorced Year or Dates. 1943-46 White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) filed within 72 al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) 8 Electrician Steel Production æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown should be file and Mental F is marked o ပ Marciszewski Frank Stella 1 and 2 should be feeth and Me item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>105 Breakwater Court, Joppa.</u> <u>Michael Marciszewski</u> MD 21085 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit, Page 1 a Department of H Important; If ite any injury or ot cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Rosary 11/27/2010 Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Priysiciani ALZHEMER'S DEMENTIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) ng physician ar as the burial-t Physician/Medical Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death ase 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? for Day Month Year Yes 2 No signed by the a d be detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Records, TRACT URIMANY 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? Yes 2 No Division of Vital Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: ᅆ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Sother (Specify) this s after death.

I Director: After this of in by the funeral di 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours af
To the Funeral Di
completed filled ir Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) zerro 240480 NOVEMBER 2 7602 Balair 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

back

FEMMO.

32. Registrar's Signature

FERNANDO

NOV 2 9 2010

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER 21, 2010 MORGERETH HERMAN F. 5:30a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death IVY HALL GERIATRIC CENTER MIDDLE RIVER BALTIMORE 5. Social Security Number 8. Date of Birth

JAN - 24,1922 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 1 X M 2 D F Hours 215-18-5044 Director 88 Yrs MARYLAND Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD N/A BALTIMORE 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 803 S. FAGLEY STREET 21224 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Force Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify. WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) MAINTENANCE CITY OF BALTIMORE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည HENRY Η. MORGERETH BARBARA KOEHLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SOUTHALL/ NIECE CAROL 806 ETON ROAD, TOWSON, MARYLAND 21204 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 \square Cremation 3 \square Removal from State injury or SACRED HEART OF JESUS 11/23/10 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Sovice Licensee Name and Addre CONKLING 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ yes wal disease or condition Medical resulting in death) ue to (or as a consequence of) Examiner Ewin Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Pregnant at time of death Month Day Year 2 🗌 No the Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 No 2 NO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 Yes 2 10 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1¹□ Natural injury 5 Pending work? 1 Tes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ASTERN BLUD, 109 M.D - 21221

State Registrar 31. Date filed (Month, Day, Year)

NASERM

32. Registrar's Signature

Division or Vital Records, P.O. Box 68760. Hospital

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2434 AJANI MI BABATUNDE 31. Date filed (Month, Day, Year) NOV 9 9 20

29b. Signature and title of certifier

2 9

W. BELVEDERE 32, Registrar's Signature

MYSICIAN

29c. License number

130064533 LEVIN DALL

GERIAT RIC

NENW

29d. Date signed (Month, Day, Year)

BALTIMORE MS 21215

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year MAJOR NGEL 12: SZAM NOV 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HARBOR HOSPITAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 PA 8. Date of Birth (Month, Day, Year) DEC 6, 1917 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 92 Director 215.01.3061 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2xxNo Director ANNE ARUNDEL **BROOKLYN PARK** MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö items 23a 613 HAMMONDS LN. 21225 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married ☐Yes 2 XXVo 1 □Yes 2 No ō, If Yes, Give Year or Dates: δ Specify 3 Widowed 4 □ Divorced WHITE "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME of Health and Mental Hygie item 27 is marked other other traumatic event, in 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ UNK UNK 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOROTHY L. MCCULLOUGH DAUGHTER 2500 FIVE SHILLINGS RD. FREDERICK MD 21701 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of the Important: If ite any Injury or ot once. 1 XX Burial 2 XX cremation 3 □ Removal from State CEDAR HILL **CEMETERY** 11.24.2010 4 ☐ Donation 5 ☐ Other (Specify) BROOKLYN, MD 21. Signature Fire rai Service Lious 22. Name and Address of Facility FINK FUNERAL HOME, P.A. GRECORY FINK M01148 426 CRAIN HWY SW GLEN BURNIE, MD 21061 olications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or com shock, of heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician PNEUMONIA 6 DAYS /Medical Examiner CONGESTIVE HEART FAILURE Sequentially list conditions, if any, leading to immunate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Physician/Medical attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No cate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 CORONARY ARTERY DISEASE, ATRI 1 ☐ Yes 2 ☐ No 3 Probably 4 Nonknown FIBRILLATION, HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate HYPERLIPIDEMIA 2 **1**No 1 ☐ Yes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Npatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number

State Registrar DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, 2 9 2010

3001 S. HANOVER ST BALTIMORE MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHETH

ORIGINAL

RESOO 1

MD

29d. Date signed (Month, Day, Year)

22 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20b, perFH, G910/12/2/2010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Prisca Nwadiko Medical 1:00 p M 19 2010 November 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3707 WILDOR AVENUE BALTIMORE CO WINDSOR MILLS 5. Social Security Number 6. Sex **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
DEC • 26 1967 9. Birthplace (State or Foreign 1 □ M 2XXF Months Days Hours Director Yrs 220-71-6716 42 NIGERIA Usual Residence of Decedent ra!", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MARYLAND BALTIMORE WINDSOR MILL 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3707 WILDOR AVENUE 21244 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 - Widowed 4 - Divorced Completed Specify: NIGERIAN 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12yrs 4yrs NURSING STUDENT BCCC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ unknown CAROLINE DURU 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samuel Nwadike/Husband 3707 Wildor Ave., Windsor Mill, Maryland 21244 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Unk 20c. Location - City or Town, State 1 X Burial 2 Cremation 3XXRemoval from State 4 Donation 5 Other (Specify) NWADIKE COMPOUND IMO STATE NIGERIA 21. Signature of Finera 22 Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A.
1206 W NORTH AVENUE, BALTIMORE, MD., 21217 Marin 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician. helastalie Onset and Death Brown Cance disease or condition 6 years Medical resulting in death) Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate Physician/Medical Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month Day sate has been signed by the g page 2 should be detached i 1 ☐ Yes 2 ¶ 9 ☐ Unknown g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed 1 ☐ Yes 2 @ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 24 hours after death.

Funeral Director: After this certificate I leted filled in by the funeral director, pag performed? Yes 2 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🕒 No Certificate: To 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 🖭 Natural 5 Pending injury 2 Accident Investigation 1 Yes 2 No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed f (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 019714 secion 30. Name and address of person who completed ise of death (Item 23a) (Type, Print) PURTEIL 4940 EASSORY AVE BILTIMURE MO ZIZZY MI LYDICK JHPVML 31. Date filed (Month, Day, NOV 2 9 32. Registrar's Signatur State 2010 Registrar

State of Maryland / Department of Health and Mental Hygien for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ DAVID STEVEN O'NEILL Month Vear 2010 7.35 Medical Movember 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Greater Baltimore Medical Towson Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 **X** M 2 □ F Months Days Hours Min. Sept 23, Vrs 1946 Maryland Director 219-42-9876 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any Injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland Baltimore County Timonium 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 USA 67 Arverne Court 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 XI Yes 2 \(\text{No } 68-70 \)
If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: White Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Probation Agent State of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ည David Francis O'Neill Marjorie Emerson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arlene F. O'Neill, (Wife) 67 Arverne Court, Timonium, Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Owings Mills, MD MD Vet. Cem.,Garrison 12/3/2010 4 Donation 5 Other (Specify) Signature of Funeral Service Dicery e

Martin D. Lawson MTTCHELL WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying alluk law requires that the death certificate be executed Cause (Disease or ii that initiated events Due to (or as a consequence of) resulting in death) Last physician a s the bunal-Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Year Day Yes 2 No been signed by the should be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 autopsy performed? Yes 2 No Hospital or Attending Physician: The 1 Yes 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death (Check only one) Hospital: 2 No Other: 1 Tes မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 14 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 11-25-2010 when 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Registrar's agnature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ^{Day} 2010 Рм Bertha Offenbacker 12 Lee Nov. 8:45 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Calvary Care Burtonsville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6 Sex 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Dec. 14, 1912 1 □ M 2 🗓 F Months Days Hours Min. 225-20-7435 Director 97 Usual Residence of Decedent 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 ☐ No Maryland | Montgomery Burtonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15721 Allnutt Lane 20866 Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 Yes : Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 XWidowed 4 ☐ Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. tem 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Cafeteria Worker Cafeteria Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be Frank H. Meadows Nettie Lee Meadows 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry D. Bailey (Executor) 5297 Mill Creek Rd., Luray, VA 22835 permit. Page 1 and 2 Department of Healt Important: If item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial cemetery, crematory or other place) 🎗 🗌 Cremation 3 🔲 Removal from State 11/15/2010 injury Donation 5 🔲 Other (Specify) Beahm's Chapel Cemetery Luray, VA ature of Juneral Service Licenses 21. Sign 22. Name and Address of Facility Bradley Funeral Home 187 E. Main Street, Luray, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ ARRHYTHM

Due to (or as a consequence of): Medical resulting in death) **Examiner** RONARY TERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Z4 hours after death.
• Funeral Director. After this certificate has been signed by the attending physician and leted filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available autopsy perform prior to completion of cause of death? 1 Yes 2 No 2 X No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Assisted 1 Yes Certificate: To 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Dother (Specification) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2. 3 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0020062 Tom P. bearnaska 2010

State Registrar 8201 16th St., Silver Spring, MD 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Sig

Tony P. Kannarkat,

NOV 2 9 2010

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 2. Date of Death Physician/ Estrella Grandea Ocampo 20 10 Medical 7:51 November 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1222 Black Friars Rd. Baltimore Baltimore Social Security Number If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. **Funeral** Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign eb. 11, Year) 935 **Director** 214-38-1578 75 Philippines Usual Residence of Decedent 28a-f shov 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore Baltimore 1 ☐ Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 1222 Black Friars Road 21228 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married Black. White, etc ģ Maryland 21215-0036 1 Tyes 2 No Specify: "natural", Completed 3 Widowed 4 Divorced Specify: Asian Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Ith and Mental Hygiene.
27 is marked other than "nr traumatic event, the Med (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Registered Nurse Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental | Important: If item 27 is marked of any injury or other traumatic ewe Andres Gallenero Grandea, Sr. Primitiva Salazar 19a. Informant's Name/Relationship (Type, Print) husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Honesto</u> Calatrava Ocampo Black Friars Road; Baltimore, MD 21228 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 A Burial 2 memation 3 Removal from State Other (Specify) Arlington Nat'l Cemetery 4 Donation 5 1/12/2011 Arlington, VA vice Light 22. Name and Address of Facility
Ruck Towson Funeral Home,
1050 York Rd. Towson, Md. 21. Signature of Funeral 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) herosclekos Medical Due to (or as a consequence of) Examiner abelec Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 honths?
1 Yes 2 No Pregnant at time of death Day Year 1 | Yes 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Renal 1 \square Yes 2 \square No 3 \square Probably 4 \bigwedge Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an . 24 hours after deatn.

e Funeral Director. After this certificate has hated filled in by the funeral director, page 2 s autopsy performed?

1 Yes 2 No menary 1 Yes 2 No 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) 2 No ဂ္ 1 Yes Other 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA . Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatur and title of certific 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sandia Hairston mo 100 Wyman 31 Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10c Per FH G909 H1729/10 JH State of Maryland / Department of Health and Mental Hygiene 36937 Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 04 40PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death loanisato Prince Bayview ed 49 yo Easternale SALTIMONE 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 1 □ M 2 🛛 F Months Days Hours (Month, Day, Year) 3 4 Director 219-30-1390 76 Yrs. MD Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Dundalkm Dunda1k Y Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 746 Aldworth Road 21222 USA 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. δ 1 Never Married 2 Married 1 Yes 2 XNo If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 ₺ Widowed 4 □ Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 8 Manufacturing <u>Factory Worker</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Brooke Mary Dolan 19a. Informant's Name/Relationship (Type, Print) Grand-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephanie Clinton-daughter 3002 Orlando Ave., Baltimore, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 11-26-10 4 ☐ Donation 5 ☐ Other (Specify) Baltimore National Baltimore, MD 22. Name and Address of Facility Bradley-Ashton Funeral Home 21. Signatury of Funer of Sarah 2134 Willow Spring Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line rval Betweer Immediate Cause (Final Donset and Death Physician/ ENTRYCULA disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ Month Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown the page 2 should be detached 9 Unknown To the Hospital or Attending Physician: The law requires that the within 24 hours after death, To the Funeral Director: After this certificate has been signed by the Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown peen 24a. Was an 24b. Were autopsy findings available this certificate has prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy perform 1 Yes 2 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) examiner? Hospital: 2 No Certificate: To 1 Tes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (item 23a) (Type, Print) Dept. Evergency redicine HBMC GIORGIO CAUTIO State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #29d Per PHY C910 12/07/10 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month harles Dettyphn Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death It more Ba Northwest Hospital Stown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Funeral 222-30-3648 1 X M 2 □ F Months Days Hours Min 61 Director Yre Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits 1 🗌 Yes 2 🕅 No Baltimore <u>Baltimore</u> 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 4335 Danlou Drive 21207 USA death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 6 ò 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🗓 No Specify: 3 Widowed 4 Divorced Specify: African-American "natural", Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical soc." 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5 Be**thel** AME Church Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles Pettyjohn Mildred Fisher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4113 Windflower Way, Bowie, MD 20720 Charles T. Pettyjohn Jr./Son 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) 11-30-2010 Baltimore, MD Metro Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. PORC 9200 Liberty Road, Randallstown, MD 21133 Parth. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, entock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final N Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) by the attending physician and tached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Pr≪10 d Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day To the Hospital or Attending Physician: The law requires that the dea within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached f 1 Yes 2 D Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autonsv performed Yes 2 1 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🗌 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time date and place. 29a. Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, November 22,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5401 old Gaib. Road Randall town MD 21133 lanveer (ON+ 31. Date filed (Month, Day, Year) State Registrar any 29 2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ KATHLEEN PAYNTER 1248 PM JOVEMBER 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death NORTHWEST BALTIMOLE HOSPITAL KANDALLSTOWN Social Security Number 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) MD 1 □ M 2 🛱 F Months Min. 76 Hours 220-28-2979 Director Yrs 6 1934 118 Usual Residence of Decedent 28a-f shov 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits s 23a or zou nust be notified a Funeral Director MD Sykesville Carroll 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 6033 Old Washington Road 21784 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iterr ledical Examiner r 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 【 No If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: white 3 X Widowed 4 Divorced Completed Year or Dates other than "natu 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) State of Maryland secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental F 27 is marked or traumatic eve ည Ella Adele Parlette Howard A. Hobbs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela J. Haines (daughter) Health tem 27 Sykesville, MD 21784 422 Ross Drive item 2 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot cemetery, crematory or other place) Brandenburg UMC Cemetery 1 K Burial 2 Cremation 3 Removal from State 11/24/2010 Berrett, MD 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service License Haight funeral Home & Chapel P.O. Box 195 Sykesville, MD apel, P.A. MD 21784 (410-795-1400) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ SEPSIS Medical Due to (or as a consequence of): **Examiner** URINARY TRACT INFECTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filied in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Petal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death Unknown Part II. **Oth**er si**gnificant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide
Homicide Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examine the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one Cortifying N dertifie 29b. Signati 2010 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RANDALLSTOWN 21132 COURT RD Aumeo 5401 OLD

DHMH 17 Rev 7/2009

State Registrar

31. Date filed (Month, Day, Year)

M.D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month November 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore washington medical Cen 61en BUCALE Anne Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2**X**□ F Months Min. Hours Country)
Maryland **Director** <u> 218–15–2675</u> Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Co. Glen Burnie 1 🗆 Yes 2 🔀 No 10e. Street and Number ō 10f. Zip Code Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a any injury or other traumatic event, the Medical Examiner must be a none. 10g. Citizen of What Country? Funeral 1044 6th Street 21060 United States 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Never Married 2 Married Completed by ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Dependent Not Self Supporting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Joel Piccioni Sheila Benway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Karen Hoyer /Caregiver 102A 6th Avenue Glen Burnie, MD20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 11/20/2010 Glen Burnie, MD permit. 21. Signature of Funeral Service Licens 22. Name and Address of Facility Singleton Funeral & Cremation Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061 M01121 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) (or as a consequence of Examiner neumon Sequentially list conditions, I say leading to ause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Duri to for as a consequence of, To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month Day ed by the a 9 Unknown Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? has eral Director: After this certificate filled in by the funeral director, pag Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Certificate: To 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Suicide 2 🗌 No Investigation M 1 Yes 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature 29c. License number 68240 るか completed cause of death (Item 23a) (Type, Print) Date filed (Month, Day, Year) State 9 2 Registrar

DHMH 17 Rev 7/2009

Piccioni, Angela

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 Medical <u>Sharpless</u> Paxson, November Mercer 8:30 A 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Towson Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) April 28 9. Birthplace (State or Foreign 1 🜠 M 2 🗆 F Months Hours Days Director 207-16-1935 Yrs Pennsylvania Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of wher than "natural", or items 23a or 28a-1 sho any injury or other traumatic event, the Medical Examiner must be notified at aţ 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits ems 23a or 28a-f sh r must be notified a 1 🗆 Yes 2 💢 💢 MArvland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12110 Tullamore Road, 21093 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 XXes 2 No. 1942-1945
Year or Dates. Completed by Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Tes 2XXNo Specify. 3 Divorced 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Manager Oil Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Sharpless Paxson, Jr. Mercer Ethel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093 Edithanne Paxson 12110 Tullamore Road, #206 Timonium, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Structure of Line al Service Licensee Hilltop Service Corp. 12-29-2010 Towson Maryland 22. Name and Address of Facility Ruck Towson Funeral Home. Inc. 1050 York Road au Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Chronic OF Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as nsequence of) sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔀 No Pregnant at time of death Month 5 Other (specify) Day Year the a g 🗌 Unknown Hospital or Attending Physician: The law requires that the been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an , page 2 s certificate has autopsy performed? Yes 2 No 2 🗌 No 1 Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tes 2 🔀 No Other: မ 4 ☐ Nursing Home 5 ☐ Residence 6 🗙 Other (Specify) After this 1 Inpatient 2 I ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 1 Natural 28b. Time of 28d. Describe how injury occurred 5 Pending s after death Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 24 hours a Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check To the within 2 only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) R125808 11-26-2010 1, 52mp 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anne Lewis

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

NOV 2

32. Registrar's Signature

9 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 36942 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NOVEMBER 19^{Day} 2010 ear SELMA POLLOCK PM 2230 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOWARD HARMONY HALL ASSISTED LIVING **COLUMBIA** 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)

N 1 M 2 XX Days Months Hours Min. Director SEP1 29 ay, 1918 154.09.4846 92 Usual Residence of Decedent show 10a. State 10b. County notified at with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 28a-f MD HOWARD **COLUMBIA** 1 Yes 2 XXNo ö 10e. Street and Number 10f. Zip Code 2 should be filed within 72 hours after death with the th and Mental Hygiene.
27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be 1 10g. Citizen of What Country? Funeral 6336 CEDAR LANE 21044 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian ģ 1 Never Married 2 Married Black, White, etc. 1 ☐ Yes 2XX No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No 3xx Widowed 4 □ Divorced Specify Completed Specify: WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ၉ DAVID KAPLAN RACHEL GOODFRIEND 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health a
Important: If item 27 is SON MARTIN POLLOCK 6413 LOCKRIDGE RD. COLUMBIA, MD 21044-4032 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ★ Burial 2 ☐ Cremation 3 ★ Removal from State 4 Donation 5 Other (Specify) BETH ISREAL CEMETERY NOV 26, 2010 WOOD BRIDGE, NJ Sig fund of Funeral Service Licens 🛍 NKM TUNEKATS HOME II P.A. t/a MARYLAND MORTUARY SUPPORT GREGORY FINK 426 CRAIN HWY SW GLEN BURNIE, MD 21061 MO1148 Part 1 Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a. Part 1 Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or imjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L retail deal Pregnant at time of death for in the past 12 months? Ectopic pregnancy Day Month Year be detached the Unknown g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 🏝 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 After this certificate Yes 2 X No 1 🗌 Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 X No Certificate: To Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Nother (Specify) ASSISTED filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? LIVING HOME 28d. Describe how injury occurred 1 🔀 Natural 5 Pending injury Investigation 6 Could not be 1 ☐ Yes 2 ☐ No. Accident 24 hours after deat Funeral Director: Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examine: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Certifying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2 To the F only one) 29b. Signature and title of certifie 29c. License number V D レイトイトロ NOVEMBER 20, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6334 CEDAR LANE SUITE 103 COLUMBIA, MD 21044 ANDY LAZRIS, MD

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year

10-08907
Diane Quickley

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Diane Quickley		St 1- For State	ate of Maryla		artment of rtificate of		and	Menta	al Hyg		201	0	36943	3	
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Medical Examin			Dia		Quick	ley				Month November	r 20, 2010 Year		1430 hrs		
		4a. Facility Name (if not institution 7302 Dunbrook Court		mber)		4b. City, Tow Dundall		ocation of	Death		4c. County of Baltimore		tv		
Funeral		5. Social Security Number		7. Age (In yrs. la	ast birthday)	If Under 1		If Under	24Hrs.	3. Date of Bir	th(MM/DD/YYYY)				
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Baltimore, MI permit. Pages I and 2 Department of Health a Important: If in 27 injury or other traum		20a. Method of Disposition 1 Burial 2 Cremation	3 Removal fro		Place of Dispos crematory or oth		of cemet	tery,	D	ate	20c. Location - 0	City or To	wn, State		
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// // // // // // // // // // // // //	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease												Between Onset and Death	d	
Examiner	or condition resulting in death) Due to (or as a consequence of):										\neg		_		
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Box 6876 e death certificate the attending phy ed for use as the	Sci	past 12 months? 1 Yes 2 No 9 ✓ Unk		ant at time of dea	ath -	ner (Specify)									
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, P.O. Box 6876 res that the death certificate signed by the attending phy be detached for use as the learned and the same of the detached for use as the learned 2	Turk in Other Significant Contain	Contributing to	death but not re	salang in the d	ildenying ca	use give			1 Yes		_	ly 4 Unknown			
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The state of the s										28f. Location (Street and Number or Rural Route Number, City					
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Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state (Check only one) 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated. 29b, Signature and title of certifier 29c. License number 29d. Date signed (Mon												_			
	-	29b Signature and title of certifie	111				C.M.I				29d. Date signed November 2				
		30. Name and address of person	who completed cause	e of death (Item	23a)									-	
		Margarita Korell MD.	Assistant Med	lical Examine	er 111 Pe	enn Stree	t, Balti	imore, l	MD 212	201					
Stat	te	31. Date filed (Month, Day, Year)	32. Res	gistrar's Signatul	Last					-				٦	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 36944 State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day Mildred ナブ PM 21 10 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death OAK CREST RETIREMENT COMMUNITY Parkville Baltimore County Social Security Number Under 24 Hrs. 8. Date of Birth (Month, Day, Funeral 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🗓 F Months Days Hours Vear) **Director** <u>215-09-8702</u> 98 22 1911 Dec Pennsylvania Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 23a or 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at Director 1 ☐ Yes 2 X No Maryland Baltimore County Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8830 Walther Blvd. Funeral 21234 USA 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any Injury or other traumatic event, it is Medical Examinations. Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🏋 No Specify ρ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Auditor State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Matthew John Rawlins Elizabeth M. ပ Donnick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Virginia E. Wilkinson (Niece)</u> 424 Old Trail Road, Baltimore, <u>Maryland 21212</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dul. Val. Mem Grdns 11/29/2010 Timonium, Maryland 21. Sign was a Funcial Service Lichnie MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, MD 21212 Martin D. Lawson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ned by the attending physician detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the nast 12 months? 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months Month Day Year 5 ☐ Other (specify) 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 1 □Yes 24 No 2 🗆 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1∐ Yes Other: Certification: To this 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) After 1 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 | Pending death. 2 Accident investigation 1 ☐ Yes Director: the ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by after determined 4 Homicide e Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of cartifier ٥ 29d, Date signed (Month, Day, Year) (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death 31. Date filed (Month, 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Day **Physician** Year Carroll Joseph Ratajezak 8: 5Z /Medical Navember 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Johns Hopkins Beyvich Medical Center Baltimore U.S.A. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Months Days Hours Min. 219-12-5762 1 € M 2 🗆 F 86 December 17 Director MD Usual Residence of Decedent the Maryland 10a, State ed other than "natural", or items 23a or 28a-f show event, the Wedleal Expressional technology 10c. City Town or Location 10d. Inside City Limits Director MD Baltimore Baltimore tx Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1 1026 S. Clinton St. 21224 United States Funeral Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ₽ 1 ☐Yes 2 No Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, In Ma Elementary/Secondary (0-12) College (1-4or 5+) Maintence Davis & Truck 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Fredrick Ratajczak ပ Bertha Archer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Ratajczak 3415 Chesley Ave. Baltimore Md 21234
ce of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) **№** Burial 2 Cremation 3 Removal from State Saint Stanislaus 4 ☐ Donation 5 ☐ Other (Specify) 11/22/10 Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility BALTO, MO 2/224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 30 seconds disease or condition resulting in death) ASTSTOLE /Medical Due to (or as a consequence of): Examiner Hyperkalenia Sequentially list conditions, if any, leading to immediate caus. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Zdays Examiner Due to (or as a consequence of) executed Renal failure 2days and burial-tra Due to (or as a consequence of): Box 68760 attending physician for use as the buria Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1 □Yes 2 X No 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 Yes 2 XNo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation hin 24 hours after death. the Funeral Director: 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a, Certifier (Check only one) within To the 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) RES-000 November 18, 2010 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Daniel Ruthven 301 w. Franklin St, Apt 402, Beltmore, MD 2120 MD

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1.53AM Novembe Day 4 2890 Maria T. Ricciuti Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day,) January 27 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Days Hours Mir 87 Director Washington, D.C. 578-26-3908 1923 Usual Residence of Decedent shov 10a. State 10b. County 10c. City. Town or Location injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director -28a-f 1 Tes 2 X No Maryland Anne Arundel Hanover 10e, Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 7548 Old Telegraph Road 21076 United States or items 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify: White is marked other than "natural", 3 XWidowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Maryland life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Health Department +1Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ပ Biagio Ambrogi Antonette Rossi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is John Ricciuti/Son 2533 Symphony Lane, Gambills, Maryland 21054 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State November 26, cemetery, crematory or other pla West Arundel Crematory 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 Odenton, Maryland Signature of Funeral Service License 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A. ARIE M01386 1411 Annapolis Road, Odenton, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition a such shock or condition a such shock) Approximate Interval Between Onset and Death Physician, Medical resulting in death) Bowel Disease Due to (or as a consequence of): Examiner Schemic Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transi Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent prequant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) for Pregnant at time of death Day Year signed by the or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autons certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manny of Death funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at To the Hospital or Attending Fwithin 24 hours after death.

To the Funeral Director: After it 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier

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Ricciuti

State

31. Date filed (Month, Day, Year) Registrar

only one 29b. Signature a

d title of certifie

30. Name and address of person who

completed cause of death (Item 23a) (Troe, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year),

2016

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dау **Physician** Myra lov. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town or Location of Death 4c. County of Death **Examiner** Sirac 05 Battimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Month, Day Year | 5. Social Security Number 6. Sex Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 381-34-545 1 M 2 F Director ar. 3 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the modified Examination of the fraumatic event, the modified Examination of the fraumatic event, the modified Examination of the original and once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Ves 2 No Maryland 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubar, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 □Yes 2 ☑No ģ If Yes, Give Year or Dates: Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unem 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) unknown ို 19a. Informant's Name/Relationship (Type. Print), 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) VenKins 3908 KandallStown nend Koxann 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 Removal from State Marylai 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Par 21. Signature of Fune Service Lices 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. A oximate I rval Between Onset and Death Immediate Cause (Final myo cardia Physician inforction minutes disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner artir Coronary 15 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence ot): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlant and attending physician and for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ No No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy Division of Vital 2\1 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29c, License number 29d. Date signed (Month, Day, Year)

Registrar

State

as Myra Rhan

DHMH 17 Rev 1/2001

Sinai Hospital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MVD

2. Registrar's Sign

Javillo

S.

9

31. Date filed_(Month, Day, Year)

1050N

DG 3881

Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Növember Susan Olive Rippel 2010 5:10a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7312 Ridge Road Carroll Marriottsville Social Security Number . Age (In yrs. last birthday) If Under 1 8. Date of Birth Month, Day, Yead March 24 1944 9. Birthplace (State or Foreign Country) MD **Funeral** If Under 24 Hrs. 1 □ M 2 🏋 F 66 Days Hours 216-42-2701 Director Usual Residence of Decedent 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director must be notified Carrol1 Marriottsville 28a-f 1 🗆 Yes 2 🗓 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 33a21104 7312 Ridge Road ral", or items ? 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: white 3 XWidowed 4 ☐ Divorced If Yes, Give Year or Dates "natural", Specify: traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working nd Mental Hygiene. marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) realtor real estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Eunice Ehrman William Smuck of Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1382 Sorento Circle, West Melbourne, FL 32904 Candace Kane (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot Date 20c. Location - City or Town, State cemetery, crematory or other place)
Newcomer's Cemetery 1 X Burial 2 Cremation 3 Removal from State 11-29-10 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA Duan 100764 PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Enysician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or linjury that initiated exects quence of) burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death Day Year the 9 Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 23e. Did tobacco use contribute to the cause of death? 1 Yes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performed? Yes 2 No After this certificate 1 Yes 2 No Yes 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? 2 မ 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 1 ☐ Yes 2 ☐ No 24 hours after deat Funeral Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and rson who completed cause of death (Item 23a) (T 12

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Registrar

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32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 36949 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical 4a. Facilify Name (if not institution, give street Examiner City, Town, or Location of Death 4c. County of Death MedicA -imare Funeral 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Months Hours Director ral", or items 23a or 28a-f shov Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County within 72 hours after death with the Maryland Director 10d. Inside City Limits to more 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral . Was Decedent Ever in U.S. Armed Forces? 1 Ves 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: B 3 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working DO NOT use retired Elementary/Seconday (0-12) College (1-4 or 5+) stodiar Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sur 9a. Infor 's Name/Relationship (Typ 19b. Mailing Address 1129 Dalto. 20a. Method of Disposition
1 → Burial 2 □ Cremation 3 □ Removal from State Place of Disposition (Name of 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Lice 23a. Part 1. Enter the shock, or hear disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Dementia Medical resulting in death) Due to (or as a consequence of): **Examiner** years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day ☐ Pregnant at time of death☐ Unknown Year should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by elevation myocardia 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has page 2 2 🗌 No Yes 2 N 1 T Yes completed filled in by the funeral director, case referred to medical 26. Place of Death (Check only one) examiner? 2 **№** No Other 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 23 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene 31. Date filed (Month, Day, Year 32. Registrar's Signature State 29 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 11 Day 201°0 Leonard William Simmons 25 3:50 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Crofton Care & Rehab. Anne Arundel Center Crofton Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🕅 M 2 🗆 F Months Days Hours Min 10/29/ Director 080-24-8466 80 KY Usual Residence of Decedent 28a-f shov aţ 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 10d. Inside City Limits must be notified MD 1 Yes 2 No Anne Arundel Crofton 5 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 23a 1666 Wilkshire Drive U.S.A. 21114 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. the Medical Examiner 14. Race - American Indian, Armed Forces? 9 Black, White, etc. 1 Never Married 2X Married þ 2 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: White 3 - Widowed 4 - Divorced Year or Dates. Korean Completed 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Civil Service U.S. Government other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve 2 Harold Simmons Hilda Sager 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Russo (Daughter) 8607 Wintergreen Ct.#302,Odenton,MD 21113 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation ↑5 ☐ Other (Specify) MedCure Orlando, FL 11/29/10 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 8018 Sunport Drive, Ste. 205 Orlando, FL 32809 MedCure 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Thysician/ disease or condition resulting in death) Medical Due to (or as a con a quence of): Examiner Sequentially list conditions Examine if any, leading to immediate that the death certificate be executed and -tran: that initiated events resulting in death) Last Due to (or as a consequence of): burialttending physician for use as the buria Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death Month signed by the d Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, the Hospital or Attending Physician: The law requires Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Lamown page 2 should been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? certificate 1 ☐ Yes 2 →No 2 Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: ျ 1 🗌 Yes 2 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 I DOA After this 28a. Date of injury (Month, Day, Year) filled in by the funeral 27. Manner of De Ih 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Tes 2 🗆 No Accident Investigation 24 hours after deat Funeral Director; 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier сотрыеть (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signat 29c. License number 29d. Date signed (Month, Day, Year) D53111 26 MO 2010 Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Date filed (Month, Day, Year)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ North CV 3XA m 9 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GWYNN AVENUE BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🗆 M 2 🗓 F Months Hours Min. JAN 22 NORTH CAROLINA Director Yrs 1939 71 <u>240-62-1536</u> Usual Residence of Decedent show 10b. County ian "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 🗌 No MARYLAND N/ABALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 411 GWYNN AVENUE U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Who If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2XXNo Specify: 3 X Widowed 4 □ Divorced Specify: BLACK Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the SUPERVISOR HOUSEKEEPING <u>llth grade</u> traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, and Mental is marked o ပ္ EDWARD WATSON SR. THELMA HOLDER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If item 27 is any injury or other trac <u>Eldorado Watson/Sister</u> Baltimore, <u>Gwynn Ave.</u> Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) KING MEMORIAL 11-29-10 PARK BALTIMORE, MARYLAND 21. Sign were of Funeyal Service L 22. Name and Address of Facility
WILLIAM C BROWN
1206 W NORTH AV COMMUNITY FUNERAL HOME P.A. 23a. Part 1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) **Medical** Due to (or as a consequence of): **Examiner** Sequentially list conditions rany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence on) Exami the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year signed by the a ld be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy

executed Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760

Page 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

page 2 s certificate has rector, Be ျ this funeral Certificate: within 24 hours after death.

To the Funeral Director: After completed filled in by the funer

performed? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural 5 Pending

27. Manner of Death Accident Investigation

6 Could not be

determined

1 🗌 Yes 2 🗌 No Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death of	occurred at the time, date and place, and due to t	he cause(s) and manner as stated.
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day,
010/11	-D15272	Nay 72

1 ☐ Yes 2 ☐ No

30. Name and address of gerson who completed cause of death (Item 23a) (Type, Print)

130 Dav 9

Suicide

4 Homicide

29a. Certifier

32. Registrar's Signature

State Registrar

Medical

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ lovomber Benson Strang 2010 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Doctor's Community Hospital Lanham Prince George's Social Security Number 6. Sex 1 M 2 D F If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Jan. 2, 1914 **Funeral** 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign 96 New York **Director** 063-10-1220 Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Maryland Lanham 1 ¥ Yes 2 □ No Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 6414 Brightlea Drive 20706 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 \(\tilde{\text{L}} \) Yes 2 \(\tilde{\text{L}} \) \(\text{No.} \) 1 Yes, Give \(\text{I} \) \(\text{No.} \) 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. ori Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 1 No Specify: "natural", Completed 3 Widowed 4 Divorced Specify: Year or Dates. 1945 White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me National Security Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Agency Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Strang Anna Desmond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roy Strang (Son) 6414 Brightlea Dr., Lanham, MD 20706 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Bonation 5 ☐ Other (Specify) Metropolitan Crematory 11/24/10 Alexandria, VA Signature of uneral Service / ce / ee ²² Name and Address of Facility Found & Sons Funeral Chapel 850 Sperryville Pike, Culpeper, Mun 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) HP Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Litter underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by -ARDIOHUPATH 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an HIPORUPINENIK autopsy performed? Yes 2 No prior to completion of cause of death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No Other: Certificate: To 1. Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 KNo 28b. Time of 28d. Describe how injury occurred iniury FOR ATTER GETTING ☐ Natural 5 Pending Accident 6:30 AM Investigation Inlio BED 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and the 29c. License number TI 755550 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MASURI 7525 GREENWAU

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

NOV 292010

7601 BOON POHLIM MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

ORIGINAL

D37254

OSLER DRIVE TOWSON MARYLAND

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 25 134:00AM Alexander Sivelssovemb Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death & Baltimare 15 a pital NΑ Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye. 12-09-2 Alrxander **Funeral** If Under 24 Hrs. Birthplace (State or Foreign Country) 1 X M 2 - F Months Hours Min. 229-30-1525 81 **Director** Usual Residence of Decedent 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1X☐ Yes 2 ☐ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1510 Mosher Street Apt.#6-V 21217 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1XXYes 2 No
If Yes, Give
Year or Dates. Black, White, etc. African 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: American Completed 3XWidowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. 7 is marked other than "I City of Baltimore Elementary/Seconday (0-12) 10th Grade College (1-4 or 5+) NA Bus Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Boston Sivels Bessie Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Sandra Dunnock-Daughter 22 S. Mount Olivet Lane Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Owings Mills, MD 12-07-10 4 Donation 5 Other (Specify) 21. Signature of Funeral Services icen 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore,MD 21217 23a. Firt 1. Enter the disease, or complexitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or is a consequence of) Examiner 010 nary Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iiniury that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year 1 | Yes 2 L 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 perform 1 ☐ Yes 2 🗷 No 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 70 Other: 1 mpatient 2 ER/Outpatient 3 DOA Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) Natural Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending after death.

I Director: Aff
d in by the fur 1 Tes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours a Medical 29a. Certifier crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 2010 mpleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who thern

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36955 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 26 Charles Joseph Schmitt, III 2010 10:17 P.M November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Carroll Westminster Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day Ye Sep. 18, 9. Birthplace (State or Foreign **Funeral** 1**XX**M 2 □ F Months Days Hours Min. Country) New York 57 Yrs Director 122-46-1361 1953 Usual Residence of Decedent or 28a-f show notified at 10a State 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes XX No Maryland Carroll Finksburg 0 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? United States ral", or items 23a or Examiner must be Funeral 1708 Gladmar Court 21048 America death v 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: "natural", 3 Widowed 4XX Divorced Completed White Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Handyman traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Joseph Schmitt, Jr. Frieda Hanna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau Charles J. Schmitt, Jr. (Father 1708 Gladmar Ct., Finksburg, Maryland 21048 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Faiths Crematory
& ChapeI 1 ☐ Burial 2XX Crema Nov. 30, 3 Removal from State 4 ☐ Donation 5 ☐ Other (\$pecify) Manchester, Maryland 2010 21. Signature o Funeral Consecution Signature of Funeral Consecution Signature Signatu 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 3296 Charmil Drive, Manchester, Maryland 21102 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate , or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the l IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed peen 24a. Was an 24b. Were autopsy findings available has page 2 prior to completion of cause of death?

1 Yes 2 No autopsy performe certificate Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 🗌 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred eral Director: After filled in by the funer 1 Natural
2 Accident 5 Pending injury Choked on steak work? 1 Yes 2 No 20:26 Investigation -76-2010 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Home 4261 Sylamore WS Houseed To the Hospital within 24 hours a To the Funeral L Hospital 40 Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check 29c. License 10/10/05/5/9.)(29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 38a) (Type, Print)

State

Registrar

MANCHESTER.

PIANCHESTER, ME ZILOZ

2973

32. Registrar's Signature

mo

HENDERSON!

31. Date filed (Month, Day, Year) NOV 2 9 2010

9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Anna J. Smith Nov 5:45 A M 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice Ba1timore Randa11stown 5. Social Security Number If Under 1 7. Age (In vrs. last birthdav) If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M**XX** F Months Hours April 10 1935 Min 75 Director Maryland 213-30-5359 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes XXNo MDBaltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 30 Brookshire Dr. 21136 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes XXNo Black, White, etc. XX Never Married 2 - Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: If Yes, Give Year or Dates White 3 Divorced 4 Divorced Specify. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Book Binder Bindery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Foard Smith Anna Elizabeth Konvalinka 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Craig Smith / Son Brookshire Dr. Reisterstown, MD 21136 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State All Faiths Crematory 1 Burial XXCremation 3 Removal from State 11/30/10 Manchester, MD 4 ☐ Donation ☐ Other (Specify) Chape1 21. Signature of Juneral Service Licens 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD 21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due (r as a consequence / f): Examiner Sequentially list conditions, if any hading to in reclient cause. Enter Underlying Examine Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be execute the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician d be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Month 1 ∐ Yes 2 № g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of After this certificate has funeral director, page 2 autopsy performe death? Yes 1 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Offigr (Specify) Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 🗌 No Accident Investigation hours after deat neral Director: Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours a Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29c. License number 29d. Date signed//Month. Day. Year 00043375 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

[LAKIN W- NETULETT 2835 Smith A

Registrar

31. Date-filed (Month, Day, Year,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36957 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month George Stershic, Jr. 2010 9:14 PM November Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Harford 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Yea
April 29, **Funeral** Birthplace (State or Foreign Country) 1 ▼ M 2 □ F Days Hours Min. Months Director 83 184-20-7881 Pennsylvania Usual Residence of Decedent "natural", or items 23a or 28a-f show idical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Harford Bel Air 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 805 Lancaster Dr. 21014 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, rmed Forces?

Yes 2 \(\subseteq \) No Black, White, etc. 1 Never Married 2 Married þ Yes Sive 1 ☐ Yes 2 🗓 No Specify: 3 X Widowed 4 Divorced Completed Specify: Year or Dates White ed other than "nature event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Manufacturing marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental မ George Stershic Anna Zedalis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George M. Stershic, III/Son 805 Lancaster Dr. Bel Air 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/2/2010 Crematory Glen Burnie 21. Signature of Funeral Service Lice 22. Name and Address of Facility
Miller-Dippel Funeral Home, 6415 Belair Road Baltimore MD 23a. Pa 11. Enter the dise shock, or heart fall in ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (First Physician/ Medical resulting in death) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and for use as the burial-transi or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 DH 1 🗌 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier use of death (Item 23a) (Type, Print) 30. Name and address of person who completed de State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36958 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November Betty Maza Stansbury 2010 7:10 Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
(May 22, 1930 **Funeral** 9. Birthplace (State or Foreign Months Days Hours Country) 218-26-559 **Director** MO Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD FREDERICK FREDERICK 1 🗹 Yes 2 🗆 No 10e. Street and Number ò 10g, Citizen of What Country? "natural", or items 23a o edical Examiner must be Funeral filed within 72 hours after death with 222 BROADWAY 21701 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. 3 Divorced Specify: BLACK Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 1 and 2 should be filed within 72 lof Health and Mental Hygiene. item 27 is marked other than "rother traumatic event, the Med GELCO Elementary/Seconday (0-12) College (1-4 or 5+) TH CLERK INSURANCE 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည RUSSELL GRA NETTIE ZEIGLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (50N) ERIC STANSBUR 5312 HEVERWAY FREDERICK MD 21703 permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other t other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State NOV. 23, 244 DAMASCUS MD 4 ☐ Donation 5 ☐ Other (Specify) ILWSHIP CHICOM 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility GARY L. ROLLINS FUN. ITME d. zun 110 WEST SOUTH ST FREDERIUM MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Lipretal doc.

Pregnant at time of death in the past 12 months? Month Day Year been signed by the g 🗌 Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 21 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has performed? Yes 2 No eral Director: After this certificate filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospital 1 🗆 Yes 2 No Other: 은 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mann Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. injury at 28d. Describe how injury occurred 1 V Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one D6041 11-18-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shah nson 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36959 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Month Hettie A. Stever /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ranklin square Hospita Rosedale Battimor If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8 - 14 - 1918 Birthplace (State or Foreign Country)
 P A Social Security Number 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🛈 F Months Days Hours Min. 162-12-8790 92 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location show 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Wodical Exeminer must be notified at MD Baltimore Baltimore 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8620 Kelso Drive, Apt. C-209 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ≦ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 ☐No 9 Specify Specify: White 3 Nidowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Pharmacuetical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank S. Ellis Cena Jane Behel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Zeigenfuse - Daughter 129 Hampshire Rd., Baltimore, MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Pages 1 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 11/27/10 Glen Burnie, MD 22. Name and Address of Facility 21. Signature of Funeral Se Bradley-Ashton Funeral Home 2134 Willow Spring Road, 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical D e to (or as a consequence of): Examiner Months Sequentially list conditions, Examine It any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e Hospital or Attending Physician: The law requires that the death certificate be executed. At bours after death.

Funeral Director: After this certificate has been signed by the aftending physician and letterly filled in by the funeral director, page 2 should be detached for use as the burial-transit aftending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has t autopsy performed? Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Man er of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 V Natural 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Venurus, MD

State Registrar 29000 FRANK I'M SQUARE DRIVE, BAHIMORE, MD 21237

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10-09088 Jayant P. Singh Meg

1- For State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2010 36960 Certificate of Death

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Z P	Director															
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with s 2	eral	11. Marital Status		12. Was Deceden	t Ever in U.						cify Yes or N	0- ′	14. Race -	- Americ	an Indian, Bla	ck,
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11215-0036 doe filed within 72 hours after fental Hygiene. sarked other than "natural", event, the Medical Examiner.	Be	Jawahar Prasad	l Sim	ngh							Singh					
Sa Me	ပ	19a. Informant's Name/Relation	ship (Ty	pe, Print)		19b. Mail	ing Addres	s (Street	and Num	nber or Ru	ral Route Nu	mber, Cit	y or Town	, State,	Zip Code)	
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		11/11/ 4/1	en 1 1 -	Leh v	00070	Do	pņald:	son F	uņer	al Ho	ome &	Crem	atory	y, P	d 2111	•
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DORIS **EVELYN** SEABREASE NOVEMBER 22° 2010 9:05 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death LEVINDALE GERLATRIC CENTER AND HOSPITAL BALLIMORE CITY N/A 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months 1 M 2 X Hours 06/2171928 Director 214 26 2818 82 MARYLAND Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director MD BALTIMORE ROSEDALE 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7932 33rd STREET 21237 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 WHITE 1 ☐ Yes 2 K No Specify: If Yes, Give 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) DEPT. STORE SALES of Health and Mental Hygie If item 27 is marked other r other traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) EDGAR H. LUCY HENDERSON 19a. Informant's Name/Relationship (Type, Print) HUSBAND 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a t: If item 27 is 7 or other trau EDWARD H. SEABREASE JR. 7932 33rd ST. ROSEDALE, MD 21237 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department o Important: If any injury or PARKWOOD CEMETERY 11/26/10 BALTIMORE, MD 21. Signature of Euperal Service Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTIMORE. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final enysician/ ATHEROSCIENOTIC HEART DISEAGE ORONARY disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No Yes 2 Z 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 1 Tyes 2 **W**No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) within 24 hours a Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 20a Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D31136 NOVEMBER 22 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

SRIAN (1, 31. Date filed (Month, Day, Year) 2434

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. BELVEDERE AV. BYTIMORE, NO 21215

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Nor 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 194 7 м Mark Alan Seal S Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 26220 Howard Chapel Drive Montgomery Damascus 7. Age (In yrs. last birthday) if Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) MD **Funeral** (Month, Day, Y 1 □ M 2 □ F Months Hours 220-17-3013 32 Director Dec Usual Residence of Decedent 10a. State Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits Montgomery Damascus 1 Yes 2 X No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 26220 Howard Chapel Road 20872 USA Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, rmed Forces? Black, White, etc. þ ò 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates White 1 ☐ Yes 2 ☐ Xo Specify: "natural", 3 Divorced 4 Divorced Specify: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sheet Metal Worker Sheet Metal is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 David L. Seal Janet Winkles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $26220\,$ Howard Chapel Road, Damascus, MD $20872\,$ Mrs. Janet Seal (Mother) permit. Page 1 and 2 Department of Health Important; If item 27 any injury or other tr once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) McKendree Cemetery 11/24/2010 West Friendship, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA PO Box 195 Sykesville, MD 21784 400764 Part 1. Enter the disease, or complications 1 at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day 1 Yes 2 9 Unknown Yes 2 No P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 🗌 No 1 Tes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Hospital: Other: ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2. Accident
3. Suicide
4 Homicide 1 ☐ Yes 2X No Investigation NOV 212010 UMK 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Local (Stree and Nu determined Nome amasus Medical Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed : (Check ature and title of certif 33 3010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10:54 PM OUFMBER 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ANNE ARUNDEL BALTIMORE W ASHINGTON MEDICAL GLEN BURNIE 6. Sex 1 X M 2 D F Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Months Country) 367-30-0787 33 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f shor 10b. County 10c. City, Town or Location 10d. Inside City Limits Director or than "natural", or items 23a or 28a-fs the Medical Examiner must be notified 1 Tyes 2 X No MD Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1449 Evergreen Road 21144 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2XXMarried Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 Divorced 4 Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Army Sergeant First Class ROBERT or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Wilson Stone, Sr. Thelma Holmes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Mary June Stone / wife 1449 Evergreen Road, Severn, Maryland 21144 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 XX remation 3 Removal from State cemetery, crematory or other place) 11/30/2010 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory Signature of Funeral Service Licenses 22. Name and Address of Facility 1 2nd Ave, SW Glen Burnie, MD Singleton Funeral & Cremation Services, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physiciani disease or condition resulting in death) Medical Due to (or as Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 00022483 November 22, 20+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital Dr. Glen Burnie, mp 21061 JACOBS MO 31. Date filed (Month, Day, Year 32. Registrar's Sanature State 2 9 Registrar

STONE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day 24 Physician/ Medical 6:14 PM RUTH SOMMER NOVEMBER 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death CITY SINA! HUSPITAL OF BALTIMORE BALTIMORE N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 MD Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 💢 F Days Hours Min. 0370871926 Director 216-20-7476 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Directo "natural", or items 23a or 28a-f s edical Examiner must be notified 1 Yes 2 No BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 33 STONEHENGE CIRCLE, 21208 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🔀 No 3 X Widowed 4 Divorced WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SECRETARY REAL ESTATE other Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ **BERMAN FANNYE** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 HARRY SOMMER / SON 3411 OLD POST DRIVE, PIKESVILLE, MD 21208 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) OHEB SHALOM MEM. PARK 11/26/2010 REISTERSTOWN, MD 21. Signature of Juneral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. ALD 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Physician/ UROSEPSIS DAY Medical resulting in death) Due to (or as a consequence of): Examiner 1 DA ISCHEMIA BOWEL Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Examine The law requires that the death certificate be executed Cause (Disease or linjury signed by the attending physician and doe detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Day Pregnant at time of death Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CLOSTRIDIUM DIFFICILE COLITIS 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should GASTROINTESTINAL BLEED 24b. Were autopsy findings available prior to completion of cause of autopsy performed^a death? 2 12 No Yes the Hospital or Attending Physician: To Be 25. Was case referred to medical the funeral director, 26. Place of Death (Check only one) 1 ☐ Yes 2 ₺ No Other: 1 I Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier MD NOVEMBER 24,2010 RES-000 Im Q 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2:52 PM Physician/ Shropshire 2010 Calvin NOV Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore n/a University of Maryland Medical Center 8. Date of Birth (Month, Day, Yea March 24, 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex **Funeral** Min. Hours Country) Months TX M 2 F Alabama 38 **Director** 5-02-287 Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State must be notified at Director 1 😾 Yes 2 🗌 No MD Middle River Baltimore 10g. Citizen of What Country? 10e. Street and Number ò or than "natural", or items 23a the Medical Examiner must be Funeral USA 21220 26 Squanto Ct. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11, Marital Status Black, White, etc. 1 ☐ Yes 2 🙀 No If Yes, Give 2 1 Never Married 2 Married . Page 1 and 2 should be filed within 72 hours after went of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry 16a, Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) alth and Mental Hygiene, 27 is marked other than "r r traumatic event, the Med College (1-4 or 5+) Elementary/Seconday (0-12) US Post Office Clerk llth Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Sharon Custis Albert Shropshire 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (mother) Sharon Shropshire Butcher Middle River, MD 21220 26 Squanto Ct. other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Dec. GreenMount Cremator Balto, Md. injury (4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee any ir TEUNERAL 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Septicemia Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Day Year in the past 12 months? Pregnant at time of death g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 No 3 Probably 4 Vinknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 N 26. Place of Death (Check only one) 25. Was case referred to medical completed filled in by the funeral director, Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending 2 Accident
3 Suicide Investigation within 24 hours after death To the Funeral Director: 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number 29b. Signature and title of Nov, 21, 2010 P100616 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S. Greene St Baltimore, MD Pamela Pribble 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5.30 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mel 2 nie 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day) 7. Age (In yrs. last birthday) Year If Under 24 Hrs. Funeral Days Hours 1 🔀 M 2 🗆 F West Virginia 1940 Director 219-38-2539 69 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Maryland | Anne Arundel Millersville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral United States 21108 461 Brightwood Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Armed Forces? Black, White, etc. ģ 1 Never Married 2 X Married 2 No Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: Completed 3 Widowed 4 Divorced White Year or Dates 16a Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Classified Employee Federal Government 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Alice Freda Smith Willie B. Small 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 21108 461 Brightwood Rd. Millersville, MD Nancy E. Smith / Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Glen Haven Mem. Park | 11/27/2010 |Glen Burnie, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Kirkley-Ruddick Funeral Home, P.
421 Crain Hwy. SE; Glen Burnie, ure of Ameral Service Licensee 0/ 21061 23a. Part H. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ 0 3 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 1 Live Birth
4 Pregnant a
9 Unknown been signed by the atte in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform 1 Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) hin 24 hours after death.

the Funeral Director: After this certific

mpleted filled in by the funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work? 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 110 23/ 5. 75 MISICIE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 9

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19ach Per INF &20a-c Per FH G912 2707/2011 JH
Amend Item 8 Per En North Amend Item 8 Per En For A State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** narle 126 AM Dregars November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Medical Ctr. Ba Himore. Hopkins Bayview If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) unk 09/05/1956 Birthplace (State or Foreign Country)
 Country 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Months Days Hours Min. 54 Director 242.98.8716 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County , or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important; if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ite Medical Examiner must be natified at once. 1 XYes 2 □ No Director MD BALTIMORE DUNDALK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 639 N. AVONDALE 21222 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian 1 Never Married 2 Married Yes 2 2 No Baltimore, Maryland 21215-0036 1 □Yes 2 No BLACK Specify: þ 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DISABLED NOT WORKING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HAROLD J. SEEGARS BETTY INGRAM SEEGARS ဂ္ 19a Informant's Name/Relationship (Type Print)
Genesa Seegars—Wife
BEVERLY-SEEGARS 19b Mailing Address (Street and Number of Rural Route Number City of Town, State, Zip Code) 039 N. Avondale RD. Dundalk, MD 21222 1400 PARKWOOD AVE. CHARLOTTE, NC 2820 20a. Method of Disposition 20b. Place of Disposition (Name of Section - City or Town, State & C.S. recation - City or Town, State Burial Cremation 3 Removal from State SALEM UMC CEMETERY 11.27.2010 PACELAND, SC 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility
FINK FUNERAL HOME, P.A. K. CRECORY FINK 426 CRAIN HWY SW GLEN BURNIE, MD 21061 M01148 Enter the diseas, or compications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by heart fail re. Vist on, or a cause on each line. Approximate Interval Between Onset and Death Immediate Causa (Final Physician ardio pulmonar disease or condition resulting in death) minute /Medical Due to (or as a con equence of): Examiner year 5 tails heart Sequentially list conditions, if any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami The law requires that the death certificate be execute sician and burial-trans Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 5 Other (specify) 9 Unknown s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📉 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 ☐Yes 2 No 1 ☐ Yes 2 🖾 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🕅 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident hours after death uneral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specity) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 21,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ave Baltimore, MD Eastern 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2 9 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2 DIO CLARA SCANLON Month 3 101 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death HOWARD COUNTY GENERAL COLUMBIA HOWARD If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug | 12, 1931 TAL 401 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral Director** MD Usual Residence of Decedent 28a-f shov 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21061 USA 108 Vista Ave 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married \$ Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2XXNo Specify. XXX Widowed 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 12 Business Owner Snowball Stand and Mental Hygie is marked other Be 17. Father's Name (Firs* "Idle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve Louis Bachman, Sr. Josephine Novak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Williams Daughter 108 Vista Ave, Glen Burnie, MD 21061 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2xx Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify, 21. Sig : (10 of Europs) Service Leens e Bayview Crematory Nov 29, 2010 Baltimore, MD 22. Name and Address of Facility
Fink Funeral Home, P.A. M01148 426 Crain Hwy S., Glen Burnie, MD 21061 23a. Part 1. Loter the disease, or co shock, or heart failure. List only mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Kespiratory Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): weeks Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or a a consequence of): Examir Cause (Disease or iinjury that initiated events resulting in death) Last sician and burial-tran Due to (or as a consequence of) physician s the burial Physician/Medical The law requires that the death certificate be Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) for Pregnant at time of death Unknown ed by the a detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy malnutition 1 ☐ Yes 2 ☐ No certificate 1 Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this of funeral dir Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD, D36845 Mar- Chi hanger, MD) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mbra 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Medical aminer	ROBERT FRANKLIN SMIT 4a. Facility Name (if not institution, giv 103 THREE COIN WAY U	e street and number)		GLEN	BURNI			NÖVEMB	-	0, 2010 C. County of De	2220 eath	РМ
neral ector	5. Social Security Number 6. S 216.12.7001 Usual Residence of Decedent	Sexy 1 DM 2 DF	ge (In yrs. last birth	hday) If Under Yrs. Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month Da FEB 10,		g. i	Birthplace (State of Country) MD	or Foreign
notified at Director	10a. State 10b. County MD ANNE ARUI	NDEL	10c. City, Town								10d. Inside C	ity Limits s XXX No
er must be r Funeral D	10e. Street and Number 103 THREE COIN WAY U		Sugar in 116		21060		. 0.70			Citizen of What USA		
Examiner ted by Fu	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 Yes, Give Year or Dates.	•	13. Was Decedif Yes, specif Yes 2	ify Cuban	, Mexican,				14. Race - Ai Black, Wi Specify: WH		
Important, in term 2.1 is marked outer tream natural, to ream 2.2 of 1.2	15. Decedent's (Specify only highest g Elementary/Seconday (0-12) 12			Decedent's Usua (Give kind of work life. DO NOT use ENGINEER	k done du		of worki	ng	16b.	Kind of Busines	·	
atic event, To Be	77. Father's Name (First, Middle, Last) 18. Mother's Name (First FRANK W. SMITH WILHOMENA SCH								iddle, Maiden Surname)			
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cian/ dical niner	23a. Part 1 Enter the didease, of sort shock, of heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each lin	a consequence o	-cu	of dying,	, such as c	ardiac c	r respiratory ar	rrest,		Approxima Interval Ber Onset and	tween
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the burial-tr	resulting in death) Last	Due to (or as	a consequence o	of):								
eracned for use as the burn Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant 9 Unknown	2 ☐ Fetal death at time of death	n 3 ☐ Ectopic p 5 ☐ Other (sp						23d. Date of Month		Year
ould be deta	Part II. Other significant conditions Hule Ten 8		but not resulting in	n the underlying c	ause give	en in Part I.					to the cause of c	
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in by the funera	1	be Ope Diese of In	ury 28b. T ir ir ir ir ir ir ir ir ir ir ir ir ir	njury M		at ′es 2 □ 1	No	28d. Describe I			Rural Route Numi	her
Medical Certificate: To Be Completed by Physician/Medical Exami	29a. Certifier 1 Certifying Ph		f my knowledge, o	death occured at	he time, o	date and p	lace, an	City or Tox	wn, Stat	e) and manner as	stated.	
complete	only one) 31 Certifying Nu	rse Practioner: To the	e best of my knowle	edge, death occur	ed at the	time, date a	and plac	e, and due to the	ne cause	e(s) and manner	as stated.	anner stated
	30. Marrie and address of person who	completed cause of A 2 M	teath (Item 23a) (1 4 S / 8	Type Print) N	lead	le l	d.	Linthic	.vn	MD 21	090	
State egistrar	31. Date filed (Month, Day, Year) NOV 2 9 2010	32. Regist	r's Signaure	V								

DHMH 17 Rev 7/2009

10-08873 Kathy Ann Salem

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Nathy Ann Galem		I- For State Criticate of Death Registrar		eg. No.	0 369			
Physician	1/	1. Decedent's Name (First, Middle,Last)	2. Date of Deat	th	3. Time of Death			
Medical Examine		Kathy Ann Salem 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dec	Month November	19, 2010 4c. County of Death	0940 hrs			
	ı	7567 Baltimore Annpolis Boulevard Glen Burnie		Anne Arundel				
Funeral Director		215-64-4343 1 Months Days Hours M	Irs. 8. Date of Bir	th(MM/DD/YYYY) 9. Bir Co	thplace (State or Foreign untry) VA			
Maryland 28a-f show any d at once.	Director	Usual Residence of Decedent 10a. State MD Anne Arundel Glen Burnie 10b. County Glen Burnie 10c. Street and Number 10f. Zip Code 7567 Baltimore & Annapolis Blvd 21060		^{Og.} Citizen of What Cou USA	10d. Inside City Limits 1 Yes 2 No			
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AD 2 2 shoul h and h 27 is m]2	Rashid Salem/Son 550 14th St. Arl:			, zip code)			
more, Meges I and ent of Health int: If item		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) Final Journey 1	Date 1/27/10	20c. Location - City or Woodbine				
Balti permit. Departm Importa injury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility C] 22. Name and Address of Facility C] 2700 Edmondson	Ave. B	alto., MD	F/S 21223			
Physician /Medical zxaminer		26a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):						
ted Insit	xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b						
O, the execute sician and ourial - tran	edical Ex	d. X UNPENDED AMENDED 23a,27,28a-f per ME g910 12/7/1	0 TT					
Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit codical Coefficial	Pnysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ✔ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnant at time of death 5 ☐ Other (Specify) 9 ☐ Unknown		23d. Date of delivery Month	day Year			
P.O. res that the signed by the be detache	2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		bacco use contribute to				
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ician: s certifi rector,	e l	25. Was case referred to medical examiner? Hospital: Inpatient 2 ER/Outpatient 3 DOA Other, Nur.		Residence 6 🗸 Other	Scene			
Division of Vii To the Bospital or Attending Physis within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral directors.		1 ✓ Yes 2 No 1 Impatient 2 Evolutionation 3 DOA 4 Notice 1 Notice 27. Manner of Death 1 Natural 5 Pending Investigation 1 Pending Investigation 1 Pending Investigation 1 Pending Investigation 1 Pending Investigation 1 Pending Investigation 1 Pending Investigation 1 Pending Investigation 1 Pending Investigation 1 Pending Investigation 1 Pending Investigation 1 Pending Investigation 1 Pending Investigation 1 Pending Investigation 1 Pending Investigation 1 Pending Investigation 1 Pending Investigation 1 Pending Investigation 1 Pending Investigation 1 Pending Investigation Investigatio	28d. Describe r unk	now injury occurred				
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification	3 Suicide 6 Could not be determined Specify found at home	28f. Location (S or Town S Annapol:	treet and Number of Ru tate) 56 / Balt Is Blvd, Gl	ral Route Number, City imore en Burnie,			
DIVIS To the Hospital or A within 24 hours after To the Funeral Dire completely filled in bedries of the completely filled in bedries I considered	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.		and place, and due to th	e cause(s)			
		29b. Signature and title of certifier 29c. License number O.C.M.E.		November 20, 20				
		 Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimeter 	ore, MD 21201	1				
Stat		31. Date filed (Month, Day Year) 32. Registrar's Signature NUV 2 9 2016						
Registra								
DHMH 17 Rev 1/200 OCME 2006	71	OCME						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36971 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ CHARLES TURNER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** County of Death MORE 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 M 2 🗆 F Months Hours Міп **Director** Yrs. Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 1310 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban Mexican, Puerto Rican, etc.) 12. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes Give 3 Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ no mas Urner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other i Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 A Removal from State cemetary, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 3-2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility aughn Greene Fundal Services 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory afrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final h sician/ METASTATIC Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Directo (or as a consequence or; been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 <a>Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform 2 No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 Yes 2 No 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending ☐ Accident ☐ Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🔀 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Names readings: It the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as example. (Check within 2 To the F at the time, date and place, and due to the only un 29b. Signature and tit 29c. License number 29d. Date signed (Month, Day, Year) 858 2010 Person who e of death (Item 23a) (Type, Print) 30. Name and addr npleted caus

Registrar

DHMH 17 Rev 7/2009

State

Registrar's Signat

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Thalkelmer, Adelaide

			1 - State of Maryland / De State of Maryland / De	partment of Health and Nertificate of Death	
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Adelaide Ruth Thalheimer		2. Date of Death Month Day Vear Vovember 20 2010 0745 4 M
	Examin		4a. Facility Name (if not institution, give street and number) Baltimore Weshington Medical Center 5. Social Security Number 6. Sex 17. Age (in vrs. last birthde	4b. City, Town, or Location of Death Gun Burnie If Under 1 Year If Under 24 Hrs.	4c. County of Death Anne Arundel
	Funeral Director		5. Social Security Number 220-07-5898 6. Sex 1	Months Days Hours Min	8. Date of Birth (Month, Pay, Year) 10/7/1919 9. Birthplace (State or Foreign Country) MD
	th the Maryland 3a or 28a-f show t be notified at	Funeral Director	10a. State 10b. County 10c. City, Town or MD Anne Arundel Glen	Location Burnie 10f. Zip Code	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	2 should be filed within 72 hours after death wir tth and Mental Hygiene. 27 is marked other than "natural", or items 2 r traumatic event, the Medical Examiner musi	neral	21 Main Avenue SW	21061	10g. Citizen of What Country? United States
920		þ	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates.	3. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:	acify Yes or No-Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White
21215-0036		Be Completed	(Specify only highest grade completed) (G Elementary/Seconday (0-12) College (1-4 or 5+)	cedent's Usual Occupation ve kind of work done during most of work . DO NOT use retired)	
land 2		To Be C	7 yrs. H 17. Father's Name (First, Middle, Last) 01ie Airey	omemaker 18. Mother's Nam Mae	Own Home e (First, Middle, Maiden Surname) Breeden
e, Maryland			Mas Jose E Molhom / Daughton	ailing Address (Street and Number or Run	Glen Burnie, MD 21061
Baltimore,			1XXBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, of	sposition (Name of crematory or other place) OSS Cemetery 11/24	Date 20c. Location - City or Town, State 4/2010 Glen Burnie, Maryland
Balti	permit. P Departm Importa any inju		21. Signature of Funeral Service Licensee M01121	22. Name and Address of Facility Sir	ngleton Funeral & Cremation Ave SW; Glen Burnie, MD 21061
ng.	Medical Examiner Private Automotive Automot	cal Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate run. Final trade thin. Cause (Disease or ininjury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Fa, Jux	Approximate Interval Between Onset and Death
. Box 68760	re death certificate be executed the attending physician and ched for use as the burial-transit	by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Live Birth 2 □ Fetal death	3 Ectopic pregnancy 5 Other (specify)	23d. Date of delivery Month Day Year
ls, P.O.	law requires that the de as been signed by the s 2 should be detached	ed by Pr	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Division of Vital Records,	The law ate has page 2	Completed			24a. Was an autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No
/ital	sician: certific lirector,	To Be (25. Was case referred to medical examiner? 1	26. Place of Death (Chec	k only one)
n of \	ng P fter t	cate: T	27. Manner of Death 1 Natural 5 Pending 28a. Date of injury (Month, Day, Year) injury injury injury 1 28b. Time 28b.	e of 28c. Injury at	ome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred
Divisio	i Diffe	al Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	the Hospital thin 24 hours (the Funeral I mpleted filled	Medical	29a. Certifier (Check (Check only one) 3 Certifying Physician: To the best of my knowledge, dea only one) 3 Certifying Nurse Practioner: To the best of my knowledge.	vestigation, in my opinion, death occurred a	t the time, date and place, and due to the cause(s) and manner stated
	To the contract of the contrac		29b. Signature and title of certifier Hen Franco M	29c. License number	29d. Date signed (Month, Day, Year)
	A		30. Name and address of person who completed cause of death (Item 23a) (Typ	DO27415 ore Washington A	osphi
	Stat Registra		31. Date filed (Month, Day, Year) NOV 2. 9. 2010 32. Registrar's Signature	Ke	-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 1 Physician/ 20ຶ 2010 5:25am ^M Louise Thompson Medical Martha 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sligo Creek Nursing Home Montgomery Takoma Park Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Month, Day, **Funeral** 1 M 2 T F Days Months Hours Country) GA 86 259-54-1071 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State must be notified at Director 1 Yes 2 No MD Silver Spring Montgomery 10f. Zip Code 10g, Citizen of What Country? 5 10e. Street and Number Funeral 23a 20910 USA 724 Sligo Avenue within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 XNo
If Yes, Give
Year or Dates. traumatic event, the Medical Examiner Black, White, etc. 0. ğ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black "natural", Completed 3X Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working d Mental Hygiene. marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Funeral Industry Domestic Engineer <u>7th grade</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be find Health and Mental item 27 is marked ဂ္ Essie Mae Wansley John Henry Freeman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter-724 Sligo Ave. Silver Spring, MD 20910 Department of Health Important: If item 27 any injury or other tr once. Carstine H. Thompson/in-law 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Page 1 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Cemetery 11/27/2010 Laurel, MD re of Funeral Service License 22. Name and Address of Facility Marshall-March Funeral Home 4217 9th St. NW Washignton, DC 20011 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line nterval Between Onset and Death Immediate Cause (Final Physician/ Chronic Obstructive Pulmonary Disease disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Coronary Artery Disease Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit Congestive Heart Failure Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 ANo
9 Unknown Month Year Dav Pregnant at time of death ed by the a detached f 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by or Attending Physician: The law requires 1 X Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 perform Yes 2 X No 2X No 1 🔲 Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: ၉ 1 🗌 Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After 1 X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) Hospital Medical Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D46998 11/24/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3415 Hamilton St. Ste. #1 Hyattsville, MD 20782 Steven T. Tee, MD

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

2 9 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5 MAN 2 2010 11:454 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Tate Chesapeake Hospice House Linthicum Anne Arundel Social Security Number 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days 1 M 2 D F January 25,1920 **Director** Minnesota 478-16-0550 90 Usual Residence of Decedent 28a-f show 10a. State 10b. County filed within 72 hours after death with the Maryland must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No Maryland Anne Arundel 0denton 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 829 Snow Valley Lane 21113 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Armed Forces?

1 X Yes 2 No World
If Yes, Give à 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural" Completed 3 X Widowed 4 □ Divorced War II Year or Dates Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Electrical Engineer Defense Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P Page 1 and 2 should be William S. Ulman Hope Hower 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kim Powell/Daughter 829 Snow Valley Lane, Odenton, Maryland 21113 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date November 24, 2010 cemetery, crematory or other place)
Crest Lawn Memorial
Gardens 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Marriottsville. MD 22 Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.

Pood Odenton, Maryland 21113 Signature of Funeral Service Licensee Will Erson M00672 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on with line. Interval Betweer Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** / Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed . Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No Yes 2 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 2 No 1 Tyes Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA DICE 5 Residence eral Director: After this filled in by the funeral di 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred CUSE injury 5 Pending work 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, hours after within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and or intressingular Certifying Nurse Practioner: To the best of my knowledge, death 3 occurred at the time, date and place, and due to the cause(s) and manner as stated e cause(s) and main 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 21438 mpleted cause of death (Item 23a) (Type, Print) ANNAPOLOMO 2100, MILHAR

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death November Physician/ MARY DEBORAH WEIS 2010 11:34 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore County GILCHRIST HOSPICE CENTER Towson Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral Days Hours Dec 17, 1947 1 □ M 2**X** F Months Maryland Director 216-52-7311 62 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Lutherville 1 ☐ Yes 2 X No Maryland | Baltimore County 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21093 8407 Macauley Court death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in ILS 14 Race - American Indian Armed Forces? Black, White, etc. 2 1 X Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: "natural", White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Retail Food Store Clerk Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) be 1 Chester Henry Weis, Sr. Mary Charlotte Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 i Stephanie Weis (Sister) 8407 Macauley Court, Lutherville, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State Dulaney Valley Mem. Grdns 11/30/10 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Sign e i a era (p) e// Martin D. Lawson MITCHELL WIEDEFELD FUNERAL HOME, INC 6500 York Road, Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ 16 Medical Due to (or as a or nsequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) -transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) No ed by the 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s Jas performed certificate | 1 ☐ Yes 2 ☐ No Yes 2 Hospital or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA PICE ဂ္ this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After t 1 Natural 5 Pending 2/ Accident
3 Suicia thin 24 hours after death.

the Funeral Director: Af
mpleted filled in by the fu 1 Tyes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Box 68760 Division of Vital Records, P.O.

Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier gi

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

determined

muson un Year, 32. Registrar's Signature

State Registrar 4 Homicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible? Ostate of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death Reg. No.								
Physicia Medical Exami		Month Day Year								
neulcai Exami	nei	Sandra Washingto 4a. Facility Name (if not institution, give stre			City Town or Loca		vember 18,	2010 c. County of Death	1730 hrs	
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 418 N. Glover Street 4c. County of Death N/A								
Funeral								M/DD/YYYY) 9. Birtl		
Director		218-86-2207 I□M	2KF 48	Yrs.	Months Days H	Hours Min. 4	/2/62	Foreigr Cou	iu fM D	
<u> </u>		Usual Residence of Decedent 10a. State 10b. County	Idon City To	own or Location						
i iow any		MD N/A	•	imore					10d. Inside City Limits 1 XYes 2 No	
Maryland 28a-f show d at once.	ctor	10e. Street and Number			f. Zip Code		10g C	tizen of What Coun		
ith the Maryland 23a or 28a-f sho notified at once	Director	418 N. Glover St	•		21224			SA	.,,,	
MD 21215-0036 2 should be fited within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23s or 28s-f shomatic event, the Medical Examiner must be notified at once	eral		Was Decedent Ever in U.S.	13. Was De	ecedent of Hispanio	c Origin? (Specify '	res or No-	14. Race - Americ	an Indian, Black,	
r death or ite	Funeral	1 Never Married 2 Married 1	Armed Forces? Yes 2 No			xican, Puerto Rican	, etc.)	White, etc. Africal	n	
rs afte ural",	þ	3 X Widowed 4 Divorced If Ye or Divorced If Ye o	ates:		s 2 No spe	ecify: Give kind of work do	Lai	Specify:		
2 hou "nati	ompleted		College (1-4 or 5+)	during most of	of working life. DO	NOT use retired)				
5-0036 led within 72 h Hygiene. l other than "n the Medical E.	mple	12		Su	perior		G	ood Sam	. Hos	
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica	S	17. Father's Name (First, Middle, Last)	<u> </u>		18.M	other's Name (First,	Middle, Maide	n Surname)		
2121 uld be fil Mental I marked	o Be	George Washington 19a. Informant's Name/Relationship (Type,	Deint)	40b Mailine Ad	Ca	rrie Ke	yer			
MD 2 id 2 shou lith and N m 27 is n	Ě		1			St.,Ba		City or Town, State,	Zip Code)	
		Regina McKenny/D: 20a. Method of Disposition	20b. Plac	ce of Disposition	(Name of cemeter			Location - City or T	own, State	
Baltimore, permit. Pages 1 an Department of Hee Important: If ite		1 Burial 2 Cremation 3 R 4 Donation 5 Other Specify:	emoval nom State	matory or other p	,	11/27	/10 Ba	lt.,MD		
Baltil permit. Departm Importa injury o		21. Signature of Funeral Service Licensee			and Address of Fa	acility				
		23a. Part I. Enter the disease, or complication	10	1512	6 Belai	Hari i r RD Ra	r CTO	se F.Sv:	5,PA 5105	
Physician M Ji		failure. List only one cause on each lin	e.					ock, or heart	Between Onset and	
Examiner			ardiac Arrhyt o (or as a consequence of):	hmia du	e to Car	rdiomegal	У		Death	
		Sequentially list conditions, b.	- (a. a.							
	ine	if any, leading to immediate Due to cause. Enter Underlying Cause	o (or as a consequence of):							
p ti	Examiner	(Disease or injury that initiated	o (or as a consequence of):							
ecul and	- 1	d	ENDED 23a,pt.I	T 27 no	r ma (01	1 1-7-11	wt			
760, icate be ex physician the burial	Medica			-	I me gji					
5876 rtifica ling ph		23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregnan	₂ Fetal de	eath 3 Ec	ctopic pregnancy	23	d. Date of delivery Month Da	ıy Year	
Box 68: death certificate attending and for use as	Physician	1 Yes 2 No 9 V Unknown 9	Pregnant at time of death		(Specify)					
O. B the de by the	튄	Part II. Other significant conditions cont	Unknown	Iting in the under	iving cause given i	in Part I. 2	3e. Did tobacco	use contribute to th	e cause of death?	
P.O. P.O. signed I be deta	b S	Obesity, Asthma	-	•	, ,				bly 4 🗸 Unknown	
Records, The law requir	ompleted					24	ta. Was an		psy findings available	
Reco The law cate has	티				<u> </u>		autopsy performed? ✓ Yes 2 1	death?	mpletion of cause of 2 No	
tal Rection: The certificate	Be C	25. Was case referred to medical			26.Place of De	eath (Check only on		10 10 105	2 140	
of Vital ng Physician After this certi neral director		examiner? 1 Yes 2 No	- Impation 2 En	VOutpatient 3	DOA Other	4 Nursing Hom	e 5 Resid	ence 6 🗸 Other:	Scene	
n of ding P h. After		1 Y Notural	8a. Date of Injury (Month, Day,Year)	b. Time of Injury	1 ' '		escribe how in	ury occurred		
Division tal or Attendi rs after death. al Director: A	Cati	2 Accident Investigation	28e. Place of Injury - At home	form street for	1 Yes 2					
Division of Vital Records, P.O. Box 68 Hospital or Attending Physician: The law requires that the death certify hours after death. Funeral Director: After this certificate has been signed by the attending cell filled in by the funeral director, page 2 should be detached for use as	Certification:	Suicide Could Hot be	(Specify)	, 141111, 311 661, 141	story, onice building		Town, State)	and Number of Rura	Route Number, City	
Divis To the Hospital or A within 24 hours after To the Yuneral Director Completely filled in by		29a. Certifier 1 Certifying Physician: T	o the best of my knowledge,	death occurred a	t the time, date an	d place, and due to	the cause(s) a	nd manner as stated		
To the Howithin 24 h	Medical	one) 2 Medical Examîner: On the	ne basis of examination and/o manner stated.	or investigation, i	n my opinion, deat	th occurred at the tir	ne, date and pl	ace, and due to the	cause(s)	
	Σ	29b. Signature and title of certifier	A		29c. License num	nber		Date signed (Mont		
		ounce	1);	m)	O.C.M.E.		No	vember 19, 201	U	
		 Name and address of person who complete Zabiullah Ali, M.D. Assistant 	,	,	reet, Baltimor	e, MD 21201				
Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signature	2		-,				
Regist	rar	NOV 29 2010 A	house fl. of	at						
DHMH 17 Rev 1/20	01		C	RIGINAL				OCAN		

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	State of Maryland	/ Department of He	ealth and Mental Hygiene

Terrence Joseph		ilson Sta 1- For State Registrar	ate of Maryland		rtment of I tificate of L		d Mental		201 eg. No.	0 3697	
Physicia Medical Examir	ın/	1. Decedent's Name (First, Middle	a,Last) unce Wils	on				2. Date of Deat Month November	th Day Year	3. Time of Death 1300 hrs	
		4a. Facility Name (if not institution 9527 Oak Trace Way	n, give street and number)		1	City, Town, or Randallstow		eath	4c. County of De Baltimore C		
Funeral Director		5. Social Security Number	6. Sex 7. Ag	e (In yrs. la	ast birthday) 36 Yrs.	Months Days		Hrs. 8. Date of Bird	th (MM/DD/YYYY) 9.	Birthplace (State or Foreign Country) Manyland	
nd show any ce.	٦.	Usual Residence of Decedent 10a. State 10b. County Maryland Bo	Ellinore	10c. City,	Town or Location	Rand	allston	vn		10d. Inside City Limits 1 Yes 2 No	
ith the Maryland 23a or 28a-f show notified at once.	Funeral Director	10e. Street and Number 9527 Oak 7	race Way	I	1	Of. Zip Code	21133	10	og. Citizen of What C	ountry?	
s after death wi	ত্র	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divo	1 Yes 2 Friced If Yes, Give Year or Dates:	No	If Yes,	specify Cuban	, Mexican, Pue specify:	(Specify Yes or No- erto Rican, etc.)	White, etc Specify: B	lack	
64 3	Completed	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, I	College (1-4 or		-	of working life.	echani	retired)	16b. Kind of Busines		
2121 ald be fil Mental F narked	å	Be	Gregory Cog	ip (Type, Print)		19b. Mailing A		Breno		ber, City or Town, Sta	ate, Zip Code) 11 112
MD straight an em 27 i		20a Method of Disposition 1 Burial 2 Cremation	on − Mothe Removal from Sta	20b. P	lace of Disposition rematory or other		yette	St. ISo	20c. Location - City	Maryland or Town, State	
Baltimore permit. Pages 1 s Department of Ho Important: If it		4 Donation 5 Other Spa 21. Signature of Funeral Service L		MH	22. Nam	CGM CFE e and Address 2 Free	of Facility	127/10 UKEN FU	neval Ho	we fit fire	
Physician /Medi_l Examiner		23a. Part I. Enter the disease, or of failure. List only one cause of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	n each line. a. Contact Gunsho Due to (or as a conse	ot Wound	d of Head	node of dying, s	such es cardia	c or respiratory arre	st, shock, or heart	Proximate Interval Between Onset and Death	
ecuted and transit	Examin	d.									
Box 68760, c death certificate be executed the attending physician and of for use as the burial - transit		UNPENDED IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month							ery Day Year		
P.O. Box es that the death or igned by the attence detached for us	좕	1 Yes 2 No 9 Unkn	э опкломп		J Other	(Specify)	ven in Part I.	23e. Did tob	pacco use contribute t	o the cause of death?	
cords, Raw requires has been sign 2 should be	Completed by							1 Yes 24a. Was are autops perform 1 Yes 2	n 24b. Were a y prior to ned? death?		
F Vital Rec Physician: The r this certificate ral director, page	9 6	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatier		ER/Outpatient 3	DOA C		sing Home 5 R	tesidence 6 🗸 Oth	er: Scene	
IVISION OF Vorted and Phater death. Director: After to be the funeral in by the funeral to the	ation	1 Natural 5 Pendir Pendir Investi	gation Nov 18, 2010	ear)	28b. Time of Injury FOUND: 1258 hrs	1 Ye	s 2 V No	Subject shot		David Namba (St	
Division To the Hospital or Attentwithin 24 hours after death To the Funeral Director- completely filled in by the	5 5	3 Suicide 6 Could not be determined (Specify) Townhouse / Rowhouse 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 9527 Oak Trace Way, Randallstown, MD 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								wn, MD	
To the Hospital within 24 hours To the Funeral completely filled		(Check only one) 2 Medical Exam 29b. Signature and title of certifier	iner: On the best of my iner: On the basis of exam and manner stated.	nination and	d/or investigation,	in my opinion,	death occurred	d at the time, date an	(s) and manner as stand place, and due to the 29d. Date signed (M	he cause(s)	
	_	30. Name and address of person w		eath /Item ?	3a)	O.C.M			November 19, 2		
2			Medical Examiner	111 F	Penn Street, E	Baltimore, M	ID 21201				

ORIGINAL

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of N State Amend Item 23a per dr Registrar	Maryland / Depa 1,01/2 Cei	artment of Heal 0/2011dhb rtificate of Deal	lth and Me <i>th</i>	ntal Hygie Reg	ene g. N2 0 1	0 3697	8	
Physicia	an/	1. Decedent's Name (First, Middle, Last)				. Date of Death Month		3. Time of Death	h	
Medi			shaar		N	November 21 2010 9:15 P M				
Exami	ner	4a. Facility Name (if not institution, give street and number,		4b. City, Town, or Local			4c. County o			
Funeral		1626 Exeter Rd. 5. Social Security Number 6. Sex 7. A	ige (In yrs. last birthday)	Westmin		Date of Birth	Carro	OLL 9. Birthplace (State or Forei	eian	
Director		212-40-5376 1□M2∑F	94 Yrs.	Months Days Hou	urs Min.	(Month, Day, You 14,	1916	Maryland	"g"	
d d	_	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo							
arylan a-f sh fied a	Director	MD Carroll						10d. Inside City Limi		
or 28	E.	10e. Street and Number	Keyma	10f. Zip Code		10	g. Citizen of Wh			
with t	Funeral	7921 Forest & Stream	Club Rd.	21757			U.S.A.			
Jeath items ier mi		11. Marital Status 12. Was Deceden	t Ever in U.S. 13. \	Was Decedent of Hispanio	c Origin? (Specify	Yes or No-		American Indian,		
36 after a r", or	dby	Armed Forces 1 □ Never Married 2 □ Married 1 □ Yes 2 □ 1 □ Yes, Give 1 □ Yes, Give 1 □ Yes, Give 1 □ Yes, Give 1 □ Yes, Give	Ž No	1 ☐ Yes 2 🎖 No Spe		,,	Specify:	White, etc.		
-00 nours latura	Completed	Year or Dates. 15. Decedent's Education	16a. Deced	dent's Usual Occupation		.16	6b. Kind of Bus	White		
215	I I	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 o	(Give	kind of work done during O NOT use retired)	most of working	1 "	ob. Killa of bus	mess moustry	- 1	
Withii Charte		11		rical			Bank			
and e filec ntal H ed otl	To Be	17. Father's Name (First, Middle, Last) Fred Flynn		18. N	Mother's Name (F. Bessie		,			
d Mel	ľ	19a. Informant's Name/Relationship (Type, Print)	dole Mellin	Address - (Otrest d A)					\dashv	
Ma 12 shouth the and t		Randy Weishaar – son		ng Address (Street and Nu 16 Exeter Rd			-	157		
Te, 1 and of Hee item		20a. Method of Disposition	20b. Place of Dispo		Date			City or Town, State		
Page Page nent cant cant to		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	i e	g Meth. Cem	. 11/27/	2010	Middlek	ourg, MD		
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anothes.		21. Signatur, of Funeral Senfice Light site	22	2. Name and Address of F	acility Hart	zler Fu	neral H	Iome		
		TUNNO & KIDHULE		E. Broadway	_ ,		•	21791	- '	
		23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each li Immediate Cause (Final	no	er the mode of dying, such ure to Thri		spiratory arrest	,	Approximate Interval Between O-x et and Death		
Pnysician/ Medical		disease or condition	s a consequence of):					4cars	-	
Examiner		Diabetes Type 2								
	Examiner	Securiticity list conditions if any, leading to immediate cause. Enter Underlying	s a consequence of):	dration						
cuted cut and transi	xam	Cause (Disease or iinjury that initiated events c.	s a consequence of):							
ox 68760	dical E	resulting in death) Last Due to (or a	5 (5) (3) 25 50 35 42 50 35 42 50 35							
760 cate b physi	edic	d								
certific	N.	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome		7			23d. Date	of delivery	d	
Box death c he atter ed for u	Physician/Me	1 Yes 2 No 4 Pregnant	at time of death 5	Country			Mont	h Day Year		
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es that the signed by be detact	ρ	Fait II. Other significant conditions contributing to death	but not resulting in the u	inderlying cause given in i	rani.			ute to the cause of death? Probably 4 Unkno		
rds requir	etec				-	24a. Was an		ere autopsy findings availab		
Records, The law requires cate has been sig	Completed					autopsy performe	pri d? de	or to completion of cause of ath?	of	
ificate or, pa	a l	25. Was case referred to medical		26 Place of	Death (Check on	1 Yes 2	No 1	Yes 2 No		
Vita ysicia ysicia ysicia	To B	examiner? 1 Yes 2 No Hospital: 1 Inpa	itient 2 ER/Outpatier	Other			ce 6 🔀 Other	son's (Specify) residence	ce	
of ng Ph fter th ineral		27. Manner of Death 1 Natural 5 Pending (Month, D	jury 28b. Time of injury			. Describe how		<u> LOIMI</u>		
ion tendii feath. for: At	Certificate:	2 Accident Investigation		M 1 ☐ Yes						
Division of Vital tal or Attending Physician: re after death. In Director, After this certificatin by the funeral director,	Cerl	4 Demicide determined 28e. Place of Ir	njury - At home, farm, stre tc. <i>(Specify)</i>	eet, factory, office	28f	Location (Stree City or Town, S		or Rural Route Number,		
Division of Vital Records, P.O. Box 68760 — To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	ical	29a. Certifier 1 Certifying Physician: To the best of	of my knowledge, death of	occured at the time, date	and place, and d	ue to the cause	(s) and manner	as stated.	- 1	
he Ho iin 24 he Fu iplete	Medical	(Check 2 ☐ Medical Examiner: On the basis of only one) 3 ☐ Certifying Nurse Practioner: To the	examination and/or invest e best of my knowledge, o	tigation, in my opinion, dea death occurred at the time,	ath occurred at the , date and place, a	time, date and p nd due to the ca	place, and due to use(s) and mann	o the cause(s) and manner st ner as stated.	stated.	
Note to the contract of the co		29b. Signature and title of certifier	240	29c. License numb	ber	290	I. Date signed (Month, Day, Year)		
		Willingh.	MO	0005	8137		11/22	110		
5		30. Name and address of person who obmpleted cause of Wilby Kup 295 St	death (Item 23a) (Type, F	Print) (+ 207	o Cupa	tminsi	Los 1	D 21157	,	
	to		trar's Signature	7 7		1	0 /			
Sta										

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Danner 050 2010 M A 25:5 70 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death Seasons Hospice/Northwest Hosp. Ctr. Randallstown **Baltimore** Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Yea 9. Birthplace (State or Foreign 1 □ M 2 🕱 F Months Davs Hours Director 81 213-24-8812 June 4. Maryland Usual Residence of Decedent 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10b. County Director 10c. City, Town or Location must be notified at 10d. Inside City Limits 28a-f 1 Yes 2 No Maryland Carroll New Windsor ò 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 1717 Dennings Rd. 21776 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ō þ 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give altimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", Completed 3 X Widowed 4 ☐ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) : If item 27 is marked other than or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) custodian public school Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ည Norman Dorsey Keeney Virgie Baugher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carroll C. Warner/ son 933 Western Chapel Rd. Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Department of Important; If any injury or once, 4 ☐ Donation 5 ☐ Other (Specify) 11/23/2010 Dennings, MD St. James Cemetery 22. Name and Address of Facility Hartzler Funeral Home 21. Signal and of Femeral Service License all Jarine (310 Church New Windsor, MD 21776 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ Chamishs disease or condition resulting in death) cars Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate
Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 No Ectopic pregnancy detached for Day Pregnant at time of death Month Year 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 2 🗌 No Yes 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 **P**No Other: 1 Tes ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Nother (Specify) 27. Manner of Death Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending (Month, Day, Year) Natural 5 Pending death. 2 🗌 No 1 Tes Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) within 24 hours a Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29c. License number D37213 20, 2010 30. Name and address of person who complete d cause of death (Item 23a) (Type, Print) Ave MD 2835 5 mth 21207 YSAIS 50 F 31. Date filed *(Month, Day, Year)* **NOV 2** 9 2010 32. Registraris Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1. Dec
hysician	
/Medical	- 1

	/Medica
ı	zamine:
ľ	- Xummici

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I've Modical Experience is set to rutified at any injury or other traumatic event, I've Modical Experience is set to rutified at any injury or other traumatic and any injury or other traumatic event, I've Modical Experience is set to a s

Baltimore, Maryland 21215-0036

Physician /Medical

Examiner

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

•	State Registrar	Cei	rtificate of	Death	Reg	j. No.		
	Decedent's Name (First, Middle, Last)				2. Date of Death	D	3. Time of Death	
ı	Alphonso William	5			Month	Day Yea	- M	
	4a. Facility Name (If not institution, give street and number)	Land	4h City Town o	r Location of Death	61	4c. County of D		
		7	- 1/	vore M		Baltin		
	Johns Hopkins Bayvien	Comment of the state of the sta	If Under 1 Year	If Under 24 Hrs.	Doto of Divito			
	52 Special Security Number 6. Sex 7. Age	(In yrs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 1 July 6,	Year)	Birthplace (State or Foreign Country)	
	110 251 1101	0.5 ris.			July 6,	1927 S.	C.	
	Usual Residence of Decedent						10d. Inside City Limits	
		10c. City, Town or Lo	cation				'	
3	MD	Ba	altimore	9			1 ☐ Yes 2 ☐ No X	
5	10e. Street and Number		10f. Zip Code		10	g. Citizen of What	Country?	
ם	1733 N. Caroline St.		21213	3		USA		
licial Dilecto	11. Marital Status 12. Was Decedent S	ver in U.S. 13.	Was Decedent of h	Hispanic Orlgin? (Sp	ecify Yes or No-	14. Race - A	merican Indian,	
5	Armed Forces?		If Yes, specify Cub	lispanic Orlgin? (Sp an, Mexican, Puerto	Rican, etc.)	Black, W		
<u>,</u>	1 □ Never Married 2 □ Married 1 □ Yes \$ □ No If Yes, Give Year or Dates:	´	1 □ Yes 2 ☑ No	Specify:		Specify: B	lack	
5		16a Dass	dantia Haval Ossu	nation	14			
Specify: Black 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5th Specify: Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) At Once Clean Service								
1	Elementary/Secondary (0-12) College (1-4or 5+) lile. I	DO NOT use retire	<i>a)</i>	I .	Service	_	
3	5th	Jan	itor					
מ	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle, Ma	aiden Surname)		
5	unknown			Sally V	William	s		
	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street	and Number or Rur			e, Zip Code)	
	Marie Frazier /friend	1722	N O-		·	- 1/3 ^	1010	
Marie Frazier / friend 1733 N. Caroline St. Balto, Md. 21213 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State								
	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, crer	natory or otner pia	ce)	1			
	4 ☐ Donation 5 ☐ Other (Specify)	Mt.Zion			1,2010	sarto,M	a	
	21. Signature of Funeral Service Licensee	22	2. Name and Addre	ess of Facility	a Funor	-1 Heme		
	10 emadene 71- Serva	<i>(1)</i>	10 F D	Scrugg: reston	s runera	ar nome	21212	
	23a. Part 1. Enter the disease, or complications that caus of	he death. Do not ent	ter the mode of dyi	ng, such as cardiac	or respiratory arres	et,	Approximate	
	shock, or heart failure. List only one cause on each line Immediate Cause (Final						Interval Between Onset and Death	
	disease or condition a.	LLMIA					J'Lhours	
	Due to (or as a	consequence of):						
	Sequentially list conditions b.	my Arten	Dise-	. 1 .			16m3	
5	Sequentially list conditions, if any, had not be important to limit and cause. Enter Underlying	consequence of:						
Evalille	cause. Enter Underlying Cause (Disease or injury that initiated events							
Š	resulting in death) Last Due to (or as a	consequence of):						
2	d							
Medical								
	IF FEMALE: 23c. If yes, outcome of	f pregnancy				23d. Date of	delivery	
ğ	23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2		Cthor (appoint)	СУ		Month	Day Year	
lysicia	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	umo or death 5 L	Other (specify)					
		not roculting in the	ndorlving source =:	on in Part	23e Did tah	acco use contribut	e to the cause of death?	
2	Part II. Other significant conditions contributing to death but	not resulting in the u	nuenying cause gr	иен предп.			×8.	
3					1 ☐ Yes	; 2 □ No 3 □	Probably 4 Unknown	
Completed					24a. Was an	24b. Were	autopsy findings available	
įΙ					autopsy perform	e 4 ? prior	e autopsy findings available to completion of cause of h?	
					1 □ Yes 2	(2No 1 1)	Yes 2□No	
ב	25. Was case referred to medical examiner?		[Ou	aari	th (Check only one			
2	1 Yes 212 No 1 100 Inpatier	t 2 ER/Outpatier	III 3 LI DOM		ome 5 🗌 Resider		Specify)	
<u> </u>	27. Manner of Peath 28a. Date of Injury 1 ☑ Natural 5 ☐ Pending (Month, Day,		Wo	ry at rk?	28d. Describe how	v injury occurred		
	2 Accident investigation			Yes 2□No				
2	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injui	y - At home, farm, str (Specify)	eet, factory, office		28f. Location (Stre City or Town,	eet and Number o	r Rural Route Number,	
	- Duilding, etc.	(Speedily)		1	ony or rown,	J.a.ioj		
2	29a. Certifier Certifying Physician: To the best o	f my knowledge, deat	h occurred at the t	ime, date and place	, and due to the ca	use(s) and manne	er as stated.	
medical cel unicaudii.	(Check only 2 Medical Examiner: On the basis of one) and manner state	examination and/or in						
í	29b. Signature and title of certifier	~~*	29c. Licen	se number	20	d. Date signed (M	Ionth, Day, Year)	
	25b. Signature and title of certifier				29			
	I hold for	1110	KES	.000		Novem	6- 20 2010	
	30. Name and address of person who completed cause of de	ath (Item 23a) (Type,	Print)					
	Richard Jahnson	4940	Ecstern	Alsen	Butte	are po	0 21224	
	31. Date filed (Month, Day, Year) 32. Registra	's 9 gnature	J					
	NOV 2 9 2010 Dener	ath (Item 23a) (Type,						
	114114							

State Registrar

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>010</u> Physician/ Month 26 1:40aM Larry Wilson VOV Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death 9. Birthplace (State or Foreign Country) Gilchrist Hospice Towson 8. Date of Birth (Month, Day, Yea Oct. 31 If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 M 2 - F **Director** 212-56-7662 60 Usual Residence of Decedent 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location Director or 28a-f sl 1 X Yes 2 I No MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò "natural", or items 23a o Funeral 21218 USA 401 E. 25th St. Apt. 10C 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 X Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black Specify: Army 3 Widowed 4 Divorced Completed Year or Dates is marked other than "natu aumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Audrey V. Wilson Leroy Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2...
Department of Health an Important: If item 27 is Balto Md 21218 10C <u>Denise Wilson/wife</u> Ε. 25th St. Apt. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Dec.7,2010 OwingsMills,MD 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL
1412 E. PRESTON ST. BALTO 21. Signature of Funeral Cervice Lice 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Veal Pregnant at time of death s been signed by the s should be detached 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been funeral director, page 2 shoul 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an CHRONIC autopsy performe 1 ☐ Yes 2X No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 1 ☐ Yes 2 🖾 No Hospital: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🖎 Natural work? 5 Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be hours a er decth uneral Director. A ed filled i by the f Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a revision to the Funeral Directory Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one 3 🔾 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 26-2010 Durp 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

N. Charl

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.	10 36982
		Hegistrar 2. Date of Death	3. Time of Death
Physic	ian		2,20/0 9 62M
/Med		4a. Eacility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. Coun	ity of Death
Exami	ner	Northwar High THI CONTER RANDA/STEWN BA	1 Travent
Funera		5. Social Security Number 6. Set 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
Directo		172-40-8672 1 M 2 XF 61 Yrs. World's 243 1001 09-19-1949	IA
pu »		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
aryla shov	ō	Tod. Glate	1 ☐ Yes 2 💢 No
the M	Director	MD Baltimore Resters Count 10e. Street and Number 10g. Citizen County 10g. Citizen County	of What Country?
with with			ited States
5-0036 72 hours after death with the Maryland natural", or items 23a or 28a-f show actural", or items 23a or 28a-f show actural actual bar notified at	Funeral	12 / E. Citatsworth River in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Fig. 12 15. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 15. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 15. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 15. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, etc.) 15. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, etc.) 16. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, etc.) 16. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, etc.) 16. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, etc.) 17. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, etc.) 18. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, etc.) 18. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, etc.) 18. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, etc.) 18. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes) 18. Was Decedent of Hispanic Origin? (Specify Yes) 18. Was Decedent of Hispanic Origin? (Specify Yes) 18. Was Decedent of Hispanic Origin? (Specify Yes) 18. Was Decedent of Hispanic Origin? (Specify Yes) 18. Was Decedent of Hispanic Origin? (Specify Yes) 18. Was Decedent of Hispanic Origin? (Specify Yes) 18. Was Decedent of Hispanic Origin? (Specify Yes) 18. Was Decedent of Hispanic Origin? (Specify Yes) 18. Was Decedent of Hispanic Origin? (Specify Yes) 18. Was Decedent of Hispanic Origin? (Specify Yes) 18. Was Decedent of Hispanic Origin? (Specify Yes) 18. Was Decedent of Hispanic	Race - American Indian, Black, White, etc.
or iter			city:
ours a	l by	3 □ Widowed 4 X Divorced Year or Dates:	Business/Industry
5-0036 72 hours aft natural", or	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of (Give kind of work done during most of working life. DO NOT use retired)	
Par "iffiin "Bar".	ಠ	Elementary/Secondary (0-12) College (1-4or 5+) Operator Phon	ie Company
d 2121 filed within Hygiene. wher than "			name)
anc be fintal hed ot	Be	m Miriam Hackman	
iore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Marylan to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinat must be notified at	2	19h Mailing Address (Street and Number or Rural Route Number, City or To)	wn, State, Zip Code)
Ma d 2 sl th an th an trau		George Sinnott (Son) 1009 Balsam La. Eldersburg, MD 21/82	
t and 2 Health tem 27 i	1	20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location of Dat	on - City or Town, State
Pages Inent of Hant: If ite		1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Lake View Mem. Park 11-29-2010 Elders	sburg, MD
中 二十代号	once	21. Signature of Funeral Service Licensee J. Wayne Osterling 22. Name and Address of Facility ELINE FUNERAL 11824 Reisterstown Rd.	HOME town, MD 21136
Physicia		23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	Approximate Interval Between Onset and Death
/Medica	_	resulting in death)	
Examine		Sequentially list conditions b. GRAM NECATIVE BACTEREMIA	
D ##	jner i	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	
60, be executed ician and burial-transit	kam	Sequeltary list content of the first of the	
60, be ex ician ourial			
8760 icate be e physician the buria		d	
Box 68760, sath certificate be executed attending physician and for use as the burial-transit	/Me		. Date of delivery
Box eath cer attendin for use	cian	23b. Was decedent pregnant in the past 12 months? 4 Pregnant at time of death 5 Cher (specify)	Month Day Year
that the denet by the a	IVS	1 Yes 2 No 9 Unknown	
that the by detact			contribute to the cause of death?
cords, w requires t been signe should be	9	SEPTIC SHOCK RESPIRATORY FAMILY. PANCYTOPENIA 1 Yes 2 1	No 3 Probably 4 donknown
w rec	ete	$ 0\rangle$ $ 0\rangle$	24b. Were autopsy findings available prior to completion of cause of
The law cate has I page 2 s	Ĕ	Slatus Post Blue to Hazel (1205) one of the autopsy performed? ACUTE MYELOGENOUS LEUKEMIA 1 Tyes 2 2000	death? 1 ☐ Yes 2 ☑ No
Vital Fician: The certificate ector, pag		25. Was case referred to medical 26. Place of Death (Check only only)	
of Vital Physician: this certifical			
on of ding Ph	12	27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Work? 28d. Describe how injury of Injury M. 1 Nova 2 No.	ccurred
Division of Vital Records, to attending Physician: The law requires that after death. Director: After this certificate has been signe bin by the funeral director, page 2 should be come.	i i i	2 Accident investigation	Number or Rural Route Number,
r Atte	Į	3 Suicide 4 Homicide 6 Could not be determined 6 See. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Injury - At home, farm, street, factory, office building, etc. (Specify)	tunibe) of Haral Hoole Hamber,
Ital o	٥		nd manner as stated.
Hosp 4 hou Funei	200	29a. Certifier (Check only one) 29a. Certifier (Check only one)	ace, and due to the cause(s)
Division of Vital Records, P.O. Box 687 to the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the I	Apal		signed (Month, Day, Year)
5 × it		DIOCOZ NOW	MBER 22 201
		30. Name and address of person who completed cause of death/(Item 23a) (Type, Print) **Non-This Time The Control of the Contr	THE RESITED
15		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OR (ANDR B. CONANTO WD) PARTICIPAL (NAME)	(AND 21133
	State	22 Registrar's Signature	
	State	iou o o 2010 h	

DHMH 17 Rev 1/2001

amend # State of Maryland / 69 parthrent of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ r 26,2010 Roland F. S. Young November 10:50PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Greater Baltimore Medical Cente Towson If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🙀 M 2 🗆 F 216-05-1010 96 Months Days Hours Director April 18, Maryland Usual Residence of Decedent or 28a-f shov notified at show 10a. State 10c. City, Town or Location with the Maryland Director 10d. Inside City Limits MD Baltimore Towson 1 Tes 2 X No 10e. Street and Number ms 23a or must be r 10f. Zip Code 10g. Citizen of What Country? Funeral 3-303 Southerly Court 21286 U.S.A. items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. the Medical Examiner Black, White, etc. o ģ 1 Yes 2 X No If Yes, Give Year or Dates. 1 Never Married 2 Married within 72 hours after 21215-0036 1 ☐ Yes 2X No Specify: Specify: White Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Executive Administrator Construction Be filed Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ၀ Page 1 and 2 should be Clarence Young Grace Miller other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Vera V. Young-wife 3-303 Southerly Ct., Towson, MD 21286 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Hilltop Serv. Corp 11/29/10 Towson, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility William G. Dau Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death ghysician/ ASPIRATION disease or condition resulting in death) PNEUMONID Medical Examiner DEMENTA Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes XX No 3 Probably 4 Yunknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \sum Yes 2 \sum No 24a. Was an s certificate has b director, page 2 s autopsy perform 1 Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospita 1 🗌 Yes Other: မ Inpatient ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After the in by the funeral 27. Manner of Death 28a. Date of injury Certificate: 28h Time of 28c. Injury at work? 28d. Describe how injury occurred Natural Accident (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours at To the Funeral D completed filled i Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature ar d title of certifier 29d. Date signed (Month, Day, Year) 67869 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NORTH CHARLES STREET ROOM 3808 SIDHU , MD 6701 BALTIMORE MD 21204 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieften 1 - State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 6:30 P M 2010 Clarissa 11 19 Η. Yarborough 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death St. Thomas More Nursing Home Prince George's Hyattsville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 1 F Months Days Hours Min FL Vrs 267-34-9922 83 13 Usual Residence of Deceden 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25 Buchanan St. NE 20011 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: **Black** 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineer Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Andrew Hamilton Bertha Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria J. Ellis/Daughter 25 Buchanan St. NE Washington, DC 20011 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Ft. Lincoln Cemetery | 11/27/2010 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marshall-March Funeral Home 4217 9th St. NW Washington, DC 20011 part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final · ARTERIXCLEROTIC CARDIOVASULAR DISSONE disease or condition resulting in death) OWV Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of):

Physician /Medical Examiner

Physician

/Medical

Examiner

10a, State

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Director

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Funeral

Director

Item 27 ie marked other than "natural", or iteme 23a or 28a-f show other treumatic event, the Madical Examinar must be notified at

Manyland

the

72 hours after

Baltimore, Maryland 21215-0036

Sequentially list or ditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Examine physicien and s the burial-transit Physician/Medical use as the the a à 99 Completed

Medicai Certification: To

The law requires that the death certificate be executed

Box 68760

P.O. I

Records,

Division of Vital

the Hospital or Attending Physician:

his

after death.

Director: Aft

To the Hoeprand within 24 hours after deat To the Funeral Director

IF FEMALE 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4☐Pregnant at time of death
9□ Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

IN SGINCTION Cenelinal vaseview

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Vinknown

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes

25. Was case referred to medical 1 ☐ Yes 2 No 27. Manner of Death

Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Date of Injury (Month, Day Year)

Other: 4 versing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred

26. Place of Death | Check only one

5 Pending investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 4 Homicide

1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28t. Location (Street and Number or Rural Route Number, City or Town, State)

(Chack unity one)

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

DO1852

November 20, 2010

Name and address of person who completed cause of death (Item 23a) (Type, Print)

LORE, MS 4 203 Queansbury Rd Hegattoville MD 32. Registrar's Sto

Registrar

DHMH 17 Rev 1/2001

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NOVEMBER

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Division of Vital Records, P.O. Box 68760

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7	Exami	ner	4a. Facility Name (if not institution 5492 Nutwell Strange Arunde			ente		Ar	nap	Location 01is	<u>.</u> 1	Deale		Anne	e Ar	unde1	
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/lar	d be i Menta arked	욘	Thomas Abel							Mar	gare	et A.	Eas	ton			
Maryland 21215-0036	shoul and is ma		19a. Informant's Name/Relation	nship (Type, Print)			19b. Mailin	g Address	(Street a			l Route Numb			tate, Zip C	Gode)	
oʻ	and 2 Health Sm 27 Sher to		Bridgit M.	<u>Abel(Da</u>	ught						dley	Rd.	De	ale,	Md	. 2075	1
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any rigury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremati		from State	2012	emetery, cren	atory or o	h e oit ther place	h i		ate	i .	Location -	•		
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Ba	permi Depar Impo any ir		21. Signature of Funeral Service Licensee Winname Researce of Scilit Sons Mortuary, P.A. 821 West St. Annapolis, Md. 21401												1 1		
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Division of Vital Records,	s after d			rmined 28e. F	Place of Inju puilding, etc	ry - At hon :. (Specify)	ne, farm, stre	et, factory,	office		2	8f. Location (5 City or Tow			or Rural i	Route Number,	
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			29b. Signature and title of certif		iege	R. U	4	\neg	License		38			te signed			
	4 Salls		30. Name and address of perso	n who completed	cause of de	eath (Item 2	23a) (Type, Pr	int) of	2000	2 H	()	Anni	600	1	UIN	211/1	. /
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. ND#18 Per FH State of Marylar 15/2010 AACO HEALIH DEPT. OMH State of Maryland / Department of Health and Mental Hygiene For AMP State 11/ Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 02/2010 Maurice Ani 345pm ^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Severna Park Center Severna Park Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min Month, Day Year 12/192 87 Director 126-24-4987 Irad Usual Residence of Decedent items 23a or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Severna Park 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3 Westerly Way 21146 USA __ 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. <u>8</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XXNo Specify: White Specify 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Westinghouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Deena Salem Salem Ezra Ani 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Ani 3 Westerly Way Severna Park, MD 21146 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1xx Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 11/5/2010 4 ☐ Donation 5 ☐ Other (Specify) Kneseth Israel Annapolis, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hardesty Funeral Home, P.A. Taty Annapolis, MD 21401 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ - 10 years Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day g Unknown signed by that be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s autopsy performed? 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **N**0 1 🗌 Yes ည 1 Inpatient 2 Inpatient 3 Inpa this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 Tyes 2 🗌 No ☐ Accident Investigation within 24 hours after deat

To the Funeral Director:
completed filled in by the filled in by the Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Deficiency Projections: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) FC2153891 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007 Tollwater Colmy Dr. Dring, #1A, Annapolos. mb 21401

State

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

NOV 05 2010

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 _ For State Registrar	State of Ma	arylan	-	artment of I <i>rtificate of</i>			-	giene Reg. No 201	0	36988	
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ryla	d Mer marke	P P	Charles Roy Dea								augh Deat			
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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Macical Exercities In once.		21. Signature of Funeral Service Licer	see		ene ter	. Name and Addre	ss of Facilit	ty Doug	glas A.	Fiery Fu	ıner	al Home	
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>	nysici nis cer direc		examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatier	nt 2 🗆 E	R/Outpatient	3 □ DOA Oth				lence 6 Other (Specify)	
0	or Attending Physician: after death. Director: After this certifice I in by the funeral director, p	ou:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day)	y 2	28b. Time of Injury	28c. Injur Worl				ow injury occurred			
<u>sio</u>	ttend death. tor: / the fu	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be					Yes 2 🗆 I						
Division of Vital Records,	after Direction by	Certification: To	4 Homicide determined	28e. Place of Injurbuilding, etc.	ry - At non . (Specify)	ne, iarm, stre	et, factory, office		28	If. Location (S City or Tow	Street and Number o yn, State)	r Rural	Route Number,	
_ :			29a. Certifier 1 Certifying Ph	ysician: To the best o	f my know	ledge, death	occurred at the tir	me, date an	nd place, ar	nd due to the	caus e (s) and manne	er as sta	ated.	
:	c c c	fedical		niner: On the basis of and manner stat	examination ted.	on and/of Inv			ith occurred	a at the time,	date and place, and	due to	the cause(s)	
1	viti Con	Σ	29b. Signature and title of certifier	-n			29c. Licens				29d. Date signed (M		•	
	62	-			oth (term	10a\ /m n		0 (3			V 3 V (D	2	0()	
	3		DR. VASANT DATTA,					, MARY	/LAND	21740	301-739	9-71	00	

State Registrar 31. Date filed (Month, Pay, Year) 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 4, 2010 Sarah Marie Anderson 12:30 Αм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Upper Marlboro Prince George HCR - Manor Care of Largo Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Day, Ye Year 1918 1 🗆 M 2 🔀 F Months Days Hours Director ^CMaryland <u> 216-24-1860</u> Usual Residence of Decedent show 10a. State at should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director r 28a-f sh notified 1 X Yes 2 ☐ No Maryland Prince George Largo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20774 United States 500 North Harry S. Truman Drive 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: Specify: Black Completed 3 XWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Fort George G. Meade Elementary/Seconday (0-12) College (1-4 or 5+) Domestic 6th Army Base Be Maryland 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental tem 27 is marked o permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev John Powell Helen Neal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Coy Fletcher - Daughter 2712 Sansbury Road Upper Marlboro, Maryland 20774 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Lakemount
Memorial Garden 🛛 Burial 2 🗆 Cremation 3 🗀 Removal from State November 🗘 🗌 Donation 5 🔲 Other (Specify) 2010 Davidsonville, Md. 21. Signature of Funeral Service Liquid 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road NE Washington, DC 20019 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Physician/ Cardiopulmonary Failure Medical resulting in death) Due to (or as a consequence of) Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Dualto (or sella consequence of): Cause (Disease or linjury that initiated events resulting in death) Last Hypertension Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be Diabetes Mellitus P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 XNo Day Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No Yes 2 X No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☒No Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Deflicing Nurse Practices To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practices To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practices To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one tle of certifier 29b. Signature an 29c. License number 29d. Date signed (Month, Day, Year) 11-09-2010 51520 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1328 Southern Ave. SE #310 Bahram Pishadad M.D. Washington, DC 31. Date filed (Month, Day, Yea 32. Registrar Signa NOV 1 0 2010 Registrar

DHMH 17 Rev 7/2009

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na Lopez-An	nado		of Maryland / Departr	ment of Healt	h and Men	tal Hygiene	gible.				
		1- For State Registrar	Certifi	icate of Deatl	7		eg. No.				
Physic edical Exam			mador			2. Date of Dea Month Novembe		3. Time of Death 2125 hrs			
		4a. Facility Name (if not institution, give st		4b. City, T	own, or Location		4c. County of Deat	າ			
		St. Joseph's Hospital		Tows			Baltimore Cou				
Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last b	Months		Min	Co	thplace (State or Foreign ountry)			
		Usual Residence of Decedent	1 2×F 19	Yrs.		10/2	2/1991	Guatemala			
' any		10a. State 10b. County	10c. City, Tov	vn or Location				10d. Inside City Limits			
land f show	ŗo	Md Baltimo	re Cod	ckeysville				1 X Yes 2 No			
vith the Maryland s 23a or 28a-f show a e.notified at once.	Director	10e. Street and Number		10f. Zip		1	0g. Citizen of What Cou	ntry?			
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or item	Funeral	1 Never Married 2 Married	Armed Forces? 1 Yes 2 No		Cuban, Mexican	, Puerto Rican, etc.)	White, etc.				
s after ral", o	by F	or	Yes, Give Year or Dates:	Guatemala		ispanic					
2 hours afte "natural", I Examiner	ted	15. Decedent's Education (Specify only I Elementary/Secondary (0-12)	highest grade completed) 16a College (1-4 or 5+)	a. Decedent's Usual (during most of work	Occupation (Give I king life. DO NOT	kind of work done use retired)	16b, Kind of Business/	Industry			
5-0036 lled within 7. Hygiene. I other than the Medical	Completed	12th	,	Bartender			Restaura	ant			
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MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	To Be	Mauro Elias Lopez 19a Informant's Name/Relationship (Type		19b. Mailing Address		tos Amador nber or Rural Route Nun	GONZALEZ	. Zip Code)			
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours at ment of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural or other traumatic event, the Medical Examin		Aruto Hugo Lopez/U					e, Md. 21030				
ore, s l and of Heal If iten		20a. Method of Disposition 1 X Burial 2 Cremation 3		e of Disposition (Nam natory or other place)	e of cemetery,	Date	20c. Location - City or	Town, State			
Baltimore, permit. Pages I an Department of Hee Important: If ite injury or other tr		4 Donation 5 Other Specify:	Ger	neral Ceme		11/12/10	Guater				
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and M Important: If item 27 is injury or other traumatic		21. Signature of Funeral Service Licenses	100 (C)			' John T. Rh NE Wash. D.	nines Funera	al Home			
Physician		23a. Part I. Enter the disease, or implical failure. List only one cause on each	ations that caused the death. Do					Approximate Interval Between Onset and			
√Medical ≟xaminer		Immediate Cause (Final disease a. Mu	ultiple Injuries					Death			
		.	e to (or as a consequence of):								
	ner	Sequentially list conditions,	e to (or as a consequence of):								
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	Physician/Medical		AMENDED				Inches in the				
Box 68760, e death certificate but attending physical for use as the but	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnance 1 Live birth	2 Fetal death	3 Ectopic	pregnancy	23d. Date of delivery Month	/ Day Year			
OX (eath ce sattend for use	sici	1 You 2 No of Hokeover	Pregnant at time of death Unknown	5 Other (Speci	fy)		1				
O. B it the d lby the			ontributing to death but not resulti	ing in the underlying	cause given in Pa	rt I. 23e. Did to	bacco use contribute to	the cause of death?			
ing Physician: The law requires that the The law requires that the After this certificate has been signed by uneral director, page 2 should be detach	d by					1 Yes	2 No 3 Prob	pably 4 Unknown			
w requ	Completed					24a. Was autop	sy prior to o	topsy findings available completion of cause of			
Reco	mo					perfor 1 ✓ Yes		es 2 No			
Division of Vital Records, ral or Attending Physician: The law requir rs after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be the funeral director, page 2 should	Be	25. Was case referred to medical examiner?	pital: 1 Inpatient 2 ✔ ER/e		6.Place of Death (n :				
of Viling Phys After this funeral di	٦ ا	1 Yes 2 No 27. Manner of Death	28a. Date of Injury 28b		Bc. Injury at Work		Residence 6 Other	:			
ion (tending eath. or: Al	Certification:	1 Natural 5 Pending	Nov 1, 2010 203	37 hrs	1 Yes 2	No Pedestrian s	struck by auto				
Division spital or Attenc ours after death neral Director: filled in by the	tifica	2 Accident Investigation 3 Suicide 6 Could not be could n									
ospital hours uneral		4 Homicide determined 29a. Certifier 4 Continue Physician	or Town, State) York Road and Northwood Drive , MD itan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical	one) 2 Medical Examiner: On	n the basis of examination and/or								
4	Me	29b. Signature and title of certifier	nd manner stated.		License number		29d. Date signed (Mor	nth, Day, Year)			
		Chus.	011		O.C.M.E.		November 2, 201	0			
		30. Name and address of person who com Zabiullah Ali, M.D. Assistar) 111 Penn Street	. Baltimore M	MD 21201					
S	ate		37 Registrar's Signature		, Januariore, IV						
Si	tate	31. Date filed (Month, Day Year)	37 Registrar's Signature	backet.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Voa Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death (Cet Surnie Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 D F 213-24-0677 82 July 5. 1928 Maryland Director Usual Residence of Decedent or 28a-f shov 10a. State death with the Maryland 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director MD Anne Arundel Glen Burnie 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 513 Arbor Drive 21061 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black White etc. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinance. Completed by 1 Never Married 2 Married Maryland 21215-0036 WWII 1 Yes 2 X No Specify If Yes, Give 3 X Widowed 4 ☐ Divorced Specify: white Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) motor vehicle adm. director of audits Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Harold Thomas Bishop Mary Mumford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William D. H. Bishop son 513 Arbor Drive, Glen Burnie, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗵 Burial 2 🗆 Cremation 3 🗆 Removal from State Mardela Springs Cem. 11/11/10 4 Donation 5 Other (Specify) Mardela Springs, MD Signature of Funeral Service License 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** umoria Sequentially list conditions, Examine Day to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury or Attending Physician; The law requires that the death certificate be executed and -tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 E FEMALE . If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year signed by the ar 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performed?

Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: မ ER/Outpatient 3 DOA Impatient 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Director: After 1 in by the funer Natural 5 Pending Accident
Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined hours after To the Hospital 24 hours Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Gusi Lian Name and address of person who completed cause of death (Item 23a) (Type, Print) M3 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October Day Year **Physician** Sandra Haze1 Brittingham 28 OKE :15 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death County of Death Examiner ombridge -eneral If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, June 22 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Min. 1 □ M 2 😿 F Days Hours 209-34-5238 66 June 1944 Director England Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it woulded Eventher traumatic eventher and injury or other traumatic event, it would be a second to the second eventher traumatic eventher and it would be a second eventher traumatic eventher and it will be a second eventher and it will be a second eventher and e MD Dorchester East New Market Director 1 ☐ Yes 2 ☑ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 3546 Chateau Drive 21631 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: white by Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stanley Matson Edith Partridge 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jesse L. Brittingham Sr.husband 3546 Chateau Dr., East New Market, MD 21631 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dorchester Mem. Park 11/3/10 Cambridge, MD of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to Examine that initiated events burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, physician The law requires that the death certificate be Physician/Medical use as the attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) the 1 □Yes 2 🗹 No 9 Unknown n signed by tł Id be detach€ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s this certificate has autopsy performed 2. No 1 ☐ Yes 2 🗆 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 After thi funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b Time of 28c. Injury at 28d. Describe how injury occurred Certification: 1 Natural Division 5 Pending within 24 hours arter within 24 hours arter to the Funeral Director: Aft investigation 1 ☐ Yes 2 🗆 No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

21601

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Abul Arifuddowla M.D. 219 S. Washington St., Easton, MD

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 8 2010 Year 04:17ам Charles T. Brown Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ceci1 E1kton Union Hospital Social Security Number 7. Age (In yrs. last birthdav) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Funeral (Month, Day, 1 🕅 M 2 🗆 F Months Days Hours Director 219-28-2797 78 VA Usual Residence of Decedent 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD Ceci1 Rising Sun 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21911 USA 40 Leedle Circle 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: "natural", 3 XWidowed 4 ☐ Divorced White Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) General Motors Auto Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bessie Havens Clyde T. Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 124 Chesapeake City, MD 21915 Bonnie Shiles/ daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State 11/11/2010 Woodstown, NJ Lawnside Cemetery 4 Donation 5 Other (Specify) Signature of Funeral Service License 22. Name and Address of Eacility R.T. Foard Funeral Home, P.A. S. Queen St. Rising Sun, MD 21911 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one call so on each line. Approximate Interval Between Inset and Death Immediate Cause (Final Due to (or as a c of equence of) Physiciani disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to for as a consequence of Exami attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Veal Pregnant at time of death Yes 2 No g Unknown 9 Unknown is been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? 1 ☐ Yes 2 ☐ No this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital 욘 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certife Sachder 5 mi) 11.9.2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) cause of death (Item 23a) (Type, Print)
126 A, E High ST, Elkin MD21921.

DHMH 17 Rev 7/2009

State Registrar

S.S EACHDEN MD 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend #5trace of Maryland #5trace of Maryland #5trace of Death

Certificate of Death

		Reg. No.											
Physicia dical Examination	ın/	1. Decedent's Name (First, Middle, Last) Shavonne Laverne Pee- Bynum Shavonne Laverne Bynum Shavonne Laverne Pee- Bynum November 13, 2010 3. Time of Month Day Year November 13, 2010											
7		4a. Facility Name (if not institution, give street and nu Doctors Hospital		4	b. City, Tow		ation of Death		4c. County of Deat Prince Georg				
		·	7 A . // last	inth day.	If Under 1		f Under 24Hrs.	8 Date of Bir	th/MM/DD/VVVV 9 Bir	thplace (State or Foreign			
Funeral Director		5. Social Security Number 6. Sex 578–11–4 856	7. Age (In yrs. last b	Yrs.	Months		Hours Min.	03/12/	/1001 Co	Lifornia			
	L			110.	<u>l</u>		L			LILOIIIIA			
any	- 1	Usual Residence of Decedent 10a. State 10b. County	10c. City, Tov	vn or Location	on					10d. Inside City Limits			
★ .,			r Templ	La Hil	le					1 X Yes 2 No			
Aaryland 28a-f show 1 at once.	힞	MD Prince George's Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Cou											
death with the Maryland or items 23a or 28a-f sho must be notifited at once.	Director	7003 Loch Raven Rd.			207				USA				
ith the			cedent Ever in U.S.	13. Was			nic Origin? (Spe	cify Yes or No		ican Indian, Black,			
ath w	uneral	1 Never Married 2 Married Armed F	orces?				exican, Puerto R		White, etc.	ican			
er de:	ഥ	1 X Yes 3 Widowed 4 Divorced If Yes, Give Yes	²∐ № ar 1999–201(0 1□	Yes 2X	No s	pecify:		Specify: Am	ican erican			
ural'	홠	or Dates: 15. Decedent's Education (Specify only highest gra		a. Decedent	's Usual Oc	cupation	(Give kind of wo	rk done	16b. Kind of Business	Industry			
2 hou	촳	Elementary/Secondary (0-12) College (1-4 or 5+)	during mo	st of workin	ng life. DC	NOT use retire	d)					
21215-0036 uld be filed within 72 hours after death with the Maryland Mental Hygeine. marked other than "natural", or items 23a or 28a-f she event, the Medical Examiner must be notified at once	ompleted		4		Sold				U.S. Army				
5-0 ed wi tygier of the M	डी	17. Father's Name (First, Middle, Last)				18.1			Maiden Surname)				
1215 Id be fill Aental H narked event, t	Be	Ernest Pee					_		ie Washingt				
ore, MD 21216 s. I and 2 should be fill of Health and Mental H If item 27 is marked her traumatic event, is	의	19a. Informant's Name/Relationship (Type, Print)						Iral Route Nur	mber, City or Town, State Hills, MD	e, Zip Code) 20748			
MD d 2 sh lth an n 27 i		Jermaine Bynum / Husban					n Rd,		20c. Location - City o				
re, s 1 an f Hea If iter		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal for	rom State cren	e of Disposi natory or oth	er place)		- L	Date	12				
Page lent o		4 Donation 5 Other Specify:	ngton	Nat'l	. Cem	0.000		Arlingto	•				
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic ex-	1	21. Signature of Funeral Service Licensee			ame and Ad				meral ome				
w 59713	1	flant a					in Hwy.		wie, MD 20	Approximate Interval			
Physician		23a. Fart I. Enter the disease, or complications that of failure. List only one cause on each line.	caused the death. Do	not enter tr	e mode of o	dying, suc	n as cardiac or	respiratory an	rest, snock, or near	Between Onset and Death			
/Medical Examiner	i	Illinediate Cadse (Final disease G.	ac arrhyh	<u>tmia</u>					·	Death			
		or condition resulting in death) Due to (or as a	a consequence of):										
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as:	a consequence of):		-								
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated C. Due to (or as.	a consequence of):										
760, icate be executed physician and the burial - transit		d											
e exectian a	Physician/Medical	☐ UNPENDED ☐ AMENDED ☐ 3	1 per me a,27.per	g913	3-24-	/52 /Y	5 тт						
cath certificate be est attending physician for use as the burial	Š	IF FEMALE: 23c. If yes,	outcome of pregnan	23d. Date of delive	-								
68/ certific iding se as t	ian	23b. Was decedent pregnant in the past 12 months?	birth nant at time of death	2 Fet	tal death ner <i>(Specif</i>)		Ectopic pregnan	су	Month	Day Year			
OX 68 eath certi e attendin for use a	/sic	1 Yes 2 No 9 V Unknown 9 Unkn		5 Ott	ner (Specii)	"							
that the detected	F.	Part II. Other significant conditions contributing	to death but not resu	lting in the u	nderlying ca	ause give	n in Part I.	23e. Did t	obacco use contribute to	the cause of death?			
, P.C.	ğ							1Ye	es 2 No 3 Pro	bably 4 🗹 Unknown			
ords, w requir us been s should b	ete							24a. Was		utopsy findings available completion of cause of			
COT law 1 has b	Completed by						-	perfe	ormed? death?				
al Recian: The l		25. Was case referred to medical			26	Place of	Death (Check o						
ital sician is cert irecto	Be	examiner? Hospital: 4	Inpatient 2 🗸 EF	₹/Outpatient		Ott		Home 5	Residence 6 Oth	er:			
n of Vi ding Physi After this	: To	1 Yes 2 No		3b. Time of I		c. Injury a	at Work?	28d. Describe	how injury occurred				
The state of Lingury (Month, Day, Year) 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28d. Describe how (Month, Day, Year) 28d. Date of Injury (Month, Day, Year) 28d. Date of Injury 28d. Injury at Work? 1 Yes 2 No 28d. Describe how (Street) 28d. Describe how (Month, Day, Year) 28d. Date of Injury 28d. Injury at Work? 1 Yes 2 No 28d. Location (Street) 28d. Describe how (Month, Day, Year)													
28 Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Town, State)										tural Route Number, City			
Division at the pital or At the purs after derail Direct filled in by	5 2 5 5 1 1 Suicide 5 Could not be determined (Specify)												
Hos Pun Fun		29a. Certifier 1 Certifying Physician: To the be	est of my knowledge,	death occur	red at the ti	me, date	and place, and	due to the cau	use(s) and manner as sta	ited.			
To the Hos within 24 h To the Fur	Medical	one) 2 Medical Examiner: On the basis and manner	stated.	or investigat		License n		are unie, ualt	29d. Date signed (M				
	Σ	29b. Signature and title of certifier	1-/			O.C.M.			November 13, 2				
		+N1.		6.1		J.J.IVI.			11010111001110,2				
		30. Name and address of erson who completed car Jack Titus MD. Deputy Chief Med		3a) 111 Per	n Street	. Baltim	nore, MD 21	201					
		01 D 12 Clad 01 11 D 17 11 1 22 E	Registrar's Signature	111101		,	,						
S	tate	31. Date filed (Month, Day, Year) 32. F	A Dignature	6 6	a Kal								

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 3, 2010ar 2:55 Lillis Jackson Bunce Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Crofton Care And Rehab Center Crofton 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex Funeral Age (In yrs. last birthday) 8. Date of Birth Days Aug. 5 1 🗆 M 2 💢 F New York 1920 084-16-1124 90 Director Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Gambrills <u>Maryla</u>nd Anne Arundel 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral USA 21054 3270 Bottner Road "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ Yes, Gir 1 Never Married 2 Married 2 X No 1 ☐ Yes 2 X No Specify. Completed 3 X Widowed 4 Divorced White Year or Dates. Ith and Mental Hygiene.
27 is marked other than "natur traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Home Maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Preston Theo Harold Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 3270 Bottner Road Gambrills, MD 21054 James Bunce/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date Baltimore Washington Crematory 1 ☐ Burial 2 🗓 Cremation 3 ☐ Removal from State 11/4/2010 Laurel, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Furreral Service Licensee 16000 Annapolis Road Bowie, MD 20715 23a Part 1 Enter In 🖮 ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Months Physician/ Congestive Heart Failure Medical resulting in death) Due to (or as a consequence of): **Examiner** Month Pulmonary Edema Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🕅 No Other: XX Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State)

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760 P.O. Records, **Division of Vital** within 24 hours after death

To the Funeral Director:
completed filled in by the

Baltimore, Maryland 21215-0036

Registrar DHMH 17 Rev 7/2009 29a. Certifier (Check

29b. Signature

Howard Schultz, 31. Date filed (Month, Day, Year) 32. Redistrar's Signature NOV 05 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

35848

ORIGINAL

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 10/31/2010 Physician/ Robert Reed Bradshaw 12:30⁴m Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 14 Silverwood Circle Apt. Annapolis Anne Arundel Age (In yrs. last birthday) Date of Birth Birthplace (State or Foreign Country) **Funeral** 1**X**XM 2 □ F Months Davs Hours Min. (Month, Day, Year) 4/19/1928 Director 220-16-8757 82 MD Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 21 No Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 14 Silverwood Circle Apt. 3 21403 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1XXYes 2 \(\subseteq \) No Korea Black, White, etc. ģ 1 Never Married 2 MX Married White If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify. Specify. Completed 3 - Widowed 4 - Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 0wner Recreational Vehicles Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Bradshaw Alice Butler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 Sliverwood Circle Apt. 3 Annapolis, MD 21403 Frances Bradshaw Wife 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/4/2010 Hillcrest Memorial Annapolis, MD Signature of Funeral Service Lies is ea 22. Name and Address of Facility Hardesty Funeral Home, P.A. d. Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cancer Onset and Death ostate Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death for use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) Month 4 Pregnant at time of death 9 Unknown cate has been signed by the page 2 should be detached g Unknown Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performa death? certificate 1 Yes 2 No ☐ Yes 2 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 No ျင 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Certificate: Natural iniury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29c. License number 29d. Date signed (Month, Day, Year)
NOVEM BER 3, 2010 ance weing, MD DSZ830 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2003 Medical Parkway #210, Anrapolis, MD

Registrar

State

Box 68760

Records, P.O.

Division of Vital

MO

NOV 05 2010

31. Date filed (Month, Day, Year)

32. Registrar's Signature

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Warren E. Bleinberger Month October 2010 4:00 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1318 Redwood Avenue Annapolis Anne Arundel Social Security Number If Under If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign (Month, Day, Year) an. 7, 1921 Days Months 201-09-1757 13/53/M 2 - F Maryland 89 Director Jan. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
U.S.A. Funeral 1318 Redwood Avenue 21403 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married TXYes 2 If Yes, Give Year or Dates. 2 No Baltimore, Maryland 21215-0036 1 Tes 2 X No Specify: Specify: White Completed 3 Divorced 4 Divorced WW II 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Electrical Engineer Western Electric 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Bleinberger Wilhemina Kobsa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1318 Redwood Avenue Annapolis, Maryland Roberta Bleinberger/wife 21403 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Veterans Cemetery : 11/5/2010 Crownsville, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph sician/ disease or condition Y-Medical resulting in death) consequence of to (or as Examiner 00 Sequentially list conditions, Examiner If any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of, attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 2 No 3 Probably 4 Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 Yes 2 No Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) 1 Tyes 2 1-No Other: မ 4 Nursing Home 5 Desidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? I Director: Af 2 🗀 No 2 Accident
3 Suicide
4 Homicide Investigation ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a

To the Funeral C Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatur and title of certifier 29d. Date signed (Month. Day, Year) 10/1/18

Registrar

State

31. Date filed (Month

s of person who completed cause of death (Item 23a) (Type, Print

0 4 2010

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.

P.O. Box 68760 Division of Vital Records,

> State Registrar

11 W Medical

29a, Certifier

(Check only one)

29b. Signature and

31. Date filed (Month.

file of certin

Griffin Davis, M.D.

V 0 4 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

<u>3001 Hospital Dr., Cheverly, MD 20785</u>

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D63688

29d. Date signed (Month, Day, Year)

11/3/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	•	For State	State o	of Marylan					nd Me			$Z \cup I$	0	369	999	
		1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death											3. Time of	f Death		
Physicia Medic		Month Day										20,	ear	0610		
Examin		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of I														
red #		Prince George'				Chev						Prince	Ceor	oe's		
Funeral		5. Social Security Number 217 42 0859	6. Sex 1 ☐ M 2 X X F	7. Age (In yrs. I:	ast birthday) Yrs.	If Under 1 Months		If Under 2 Hours		B. Date of Birt (Month Day Ct 29,	h 4 <i>Xear)</i>	9	Birthpla Countr	ace (State of y) igton D	x Foreign	
Director		Usual Residence of Decedent	M	30	113.				IC	Ct 29,	1914_	Wa	ashin	gton L	<u>C</u>	
and show	ō	10a. State 10b. County		10c. Cit	ty, Town or Loc	ation							10	d. Inside C		
Maryl 28a-f ptifie	Director	Maryland Prince	George	U	pper Mar	1boro								1 🗆 Yes	s 2 No	
a or 2	D	10e. Street and Number 10f. Zip Code 3308 Oak Street 20774										izen of Wha	t Countr			
h with ns 23 nust	Funeral	3308				20774				Un	ited	States				
r deat		11. Marital Status1 ☐ Never Married 2 ☐ Married	Armed Fo	edent Ever in U.S		Vas Deceden Yes, specify						14. Race - A Black, V	Americai White, et			
al", o	d by	3 Widowed 4 □ Divorced	15 1/2 - 01	e	1	☐ Yes 2	XXVo	Specify:				Specify:	Af	rican	Americar	
within 72 hours after giene. er than "natural", o	Completed	15. Deceder	it's Education			ent's Usual C					16b. K	ind of Busin			INICA LCA	
in 72 in 72 ie. han "	티	(Specify only nigne Elementary/Seconday (0-12)	st grade completed, College (1		(Give I life. D	ind of work on NOT use re	done dur tired)	ing most o	of working						1	
ygien ygien rt, the		12			Mai	nt Engi						Federal	_ Gov	ernmen	t	
INICAL VICELTO 2 Should be filed th and Mental Hy 27 is marked oth traumatic even	To Be	17. Father's Name (First, Middle, L Oscar Proctor	,				1			First, Middle,	Maiden :	Surname)				
mark		19a. Informant's Name/Relationsh			T					a Swann						
2 sho th an th an traun		Margaret Butle		-)						Route Number			, Zip Co	ide)		
I and I Heal		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name	of		er Mar. Dat	lboro, N		J//4 ocation - Cit	v or Tow	n. State		
age age on the life of the lif		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 Removal from		cemetery, cren Resurrec				√ov 8,							
Defitition of the Maryland Z.I.Z.13-UU30 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of health and Mental Hygiene. Department of health and Mental Hygiene. Important: If time Z? is marked other than "natural", or items Z3a or Z8a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Sign turner Funeral Pervice L							Lee Fr	uneral H	Iome :	nton, M	3 OF	<u>πα</u> d Δ1ον:	andrira	
Denmi Depart Import any ir	1 8	Moris The	Frank	mooas		erry Roa	ad, C	linton	ı, MD	20735		HIC (00.	OCI	1 ALCA	IIIII I	
		292. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between		
Allysician,	2 33	Immediate Cause (Final disease or condition as Attal Carding Carringtonics)												Onset and		
Medical Examiner		resulting in death) a. Due to (or as a consequence of):											\top			
	Į.	Sequentially list conditions, b.											_			
sit sit	i i	if any, leading to immediate cause. Enter Underlying Cause (Or as a consequence or).														
ecute and Il-tran	Examiner	Cause (Disease or iinjury that initiated events c. Due to (or as a consequence of):											+			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical		d													
ficate g phy as the	Jedi	T. 2	_ u													
ath certifica attending p	an/N	IF FEMALE: 23b. Was decedent pregnant		come of pregna Birth 2 Feta		Ectopic pre	ananev				1	23d. Date o	f deliver	у	- 1	
death death or atter	Physician/Me	in the past 12 months? 1 Yes 2 No		nant at time of o		Other (spec						Month	С	Day	Year	
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vsician: s certific director,	To Be	examiner? 1 ☐ Yes 2 📈 No	Hospital:	Inpatient 2	EB/Outpatien		Other:		(Check or	e 5 🗆 Resid	lanan C	□ 04h e = /(0	2:6-)			
g Phy er this		27. Manner of Death	28a. Date		28b. Time of		. Injury a			d. Describe h			респу)			
endin eath. re fur	lical	1 Natural 5 Pendin 2 Accident Investi	gation	iri, Day, rear)	injury	м	work?	es 2 🗆 N	No							
VISION or Attendir frer death. irector: Af	Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 28e. Place	of Injury - At ho	ome, farm, stre	et, factory, o	ffice		28	f. Location (S City or Tow		d Number o	r Rural R	loute Numl	oer,	
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2.			1						- 1							
Hosp 24 ho Fune eted f	Medical	(Check 2 Medical E	Physician: To the base	sis of examination	n and/or invest	igation, in my	opinion,	death occ	urred at the	e time, date a	nd place,	and due to	the caus	e(s) and ma	anner stated.	
o the /ithin o the	Σ	only one) 3 Certifying 29b. Signature and title of certifier	Nurse Practioner:	lo the best of my	y knowledge, c		d at the ti		and place,		-	e signed (M				
F > F 0		1 Ath	Timo					200			6	0 ())2/2	
		30. Name and address of person	vho completed caus	se of death (Item	1 23a) (Type, P						UM	018EK Y. M		4	2010	
RBL		TERRI MATIN	MD	3001	HOSP,		DR			CHEV	ERL	Y M	D	207	185	
Sta		31. Date filed (Month, Day, Year)		€ gistrar's Signat	ture							/				
Registra	ar	NOV 0 9	ZUIU	news	13. 14	arra										

Amended #20b, nls, per FD, 11/10/10, Allegany Co.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1:01 A.M Physician PATRICK J. BOYLE 10 29 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ALLEGANY 11806 BAYBERRY AVENUE CUMBERLAND If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1 💢 M 2 🗆 F Yrs. 08/08/1960 MARYLAND Director 212-82-4249 50 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits the Maryland 10a. State 10b. County 1 Yes 2 No CUMBERLAND ALLEGANY Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Examinar must be U.S.A. 644 FAYETTE STREET 21502 Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Heelth and Mental Hygiene. Important: if item 27 ie marked other the eny injury or other trainments. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 XNo If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 👿 No Specify: Specify: þ 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education
(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 NONE NONE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ELEANOR LOUISE BEIER JAMES PATRICK BOYLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 644 FAYETTE STREET, CUMBERLAND, MD MARY ANN ENGLE / SISTER Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State CUMBERLAND CREMATORY 10/30/10 CUMBERLAND, MD 4 □Denation 5 □ Other (Specify) 22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 21. Signature of Funeral Service Licenses 202 GREENE STREET, CUMBERLAND, MD of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, f heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) mp homa 4/15. 4 **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physicien and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical the IF FEMALE If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23h Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) O 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 X No 1 ☐ Yes 2□ No 1□ Yes certificete Hospital or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical 515ter's 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification; To residence this 28a. Date of Injury (Month, Day Year) After thi funeral o 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 MNatural 5 Pending l Director: A 1 Tes 2 No death. investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours of To the Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Oct. 29,2010 DO633280 4 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 22. Registrar's Signature State NOV 0 4 2010

DHMH 17 Rev 1/2001

Registrar